THE HONORABLE

CV 02-0998 #1

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CLERK U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

MERCHANTS CREDIT CORPORATION,

Plaintiff,

v

JAMES F. WALKER and ELLIE WALKER, his wife,

Defendants.

JAMES F. WALKER and ELEANOR E. WALKER, husband and wife,

Third-Party Plaintiffs,

v

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, a Colorado corporation,

Third-Party Defendant

No. CV02-0998P

NOTICE OF REMOVAL OF CIVIL ACTION PURSUANT TO 28 U S C § 1441

TO: Clerk Of The Court
AND TO All Parties
AND TO Counsel for All Parties

PLEASE TAKE NOTICE that Third-Party Defendant Great-West Life & Annuity Insurance Company ("Third-Party Defendant"), by its counsel, pursuant to 28 U.S C §§ 1441 and 1446, hereby removes the King County District Court, Northeast Division, Action

Bullivant|Houser|Bailey PC
2400 Westlake Office Tower
1601 Fifth Avenue
Seattle, WA 98101 1618
Telephone (206) 292-8930

described below to the United States District Court for the Western District of Washington at Seattle In support thereof, Third-Party Defendant states as follows.

1. Great-West Life & Annuity Insurance Company is the Third-Party Defendant in the action entitled *Merchants Credit Corporation v James F Walker and Ellie Walker v Great-West Life & Annuity Insurance Company*, in the King County Court of the State of Washington, Northeast Division, Cause Number Y1-24476

2 The Insurance Commissioner was served with a Third-Party Summons and Complaint in the State Court Action on April 8, 2002 Attached hereto as ***Exhibit A*** are copies of the process, pleadings and orders served in the State Court Action

3. Federal subject matter jurisdiction exists in this action by virtue of 29 U S C § 1132(e)(1) (Jurisdiction Grant Under Employee Retirement Security Act of 1974 ("ERISA") and 28 U.S C. § 1331 (Federal Question Jurisdiction), and 28 U.S C § 1441(c)

4. Removal to federal court is appropriate in any civil action brought in state court over which the federal district court has original jurisdiction. 28 U S.C § 1441, *Metropolitan Life Ins Co v Taylor*, 481 U.S 58, 107 S Ct. 1542, 1546, 95 L Ed 2d 55 (1987)

5 All state common law actions which relate to an employee welfare benefit plan are governed by ERISA 29 U.S.C § 1132, *Pilot Life Ins Co v Dedeaux*, 481 U S. 41, 107 S Ct. 1549, 95 L. Ed.2d 39 (1987) Any civil complaint arising under ERISA is necessarily federal in character and falls within the general federal question jurisdiction of the United States District Court. *Metropolitan Life Ins Co v Taylor, supra.* There is an actual controversy between third-party plaintiff and third-party defendant as to whether third-party plaintiff is entitled to benefits under a group employee medical plan issued by third-party

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plaintiff's employer, Puget Sound Freight Lines, Inc , and underwritten by third-party defendant Great-West Life & Annuity Insurance Company The claims by plaintiff against defendant/third-party plaintiffs are separate and independent from those asserted by defendant/third-party plaintiffs against third-party defendant Great-West Life & Annuity Insurance Company (*See* Third-Party Complaint). *See also Carl Heck Engineers, Inc. v. LaFourche Parish Policy Jury*, 622 F 2d 133, 135 (5th Cir 1980)

6 Venue is proper in the United States District Court for the Western District of Washington, in that the complaint alleges third-party plaintiff resides in King County, Washington

7 The group medical plan provided to third-party plaintiff was part of an employee welfare benefit plan underwritten by Great-West Life & Annuity Insurance Company for third-party plaintiff's employer, Puget Sound Freight Lines, Inc.. (Third-Party Complaint ¶ 24) Puget Sound Freight Lines, Inc administers claims under the plan Said employee welfare benefit plan is governed by ERISA (29 U.S C § 1003, *et seq.*) ERISA defines an "employee welfare benefit plan" as "a plan, fund or program" that is "established or maintained by an employer" to provide "employees 'medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death '" 29 U S C § 1002(1), *Metropolitan Life Ins Co v Massachusetts*, 471 U S 724, 105 S Ct 2380, 2385 (1985) Attached hereto as ***Exhibit B*** is a copy of the group policy

8. The complaint concedes that the group medical plan at issue provides such benefits; hence it is an ERISA plan (Third-Party Complaint, ¶ ¶24), *Donovan v Dillingham*, 668 F 2d 1367 (11th Cir 1992)

9 Pursuant to 28 U.S C § 1446(d), copies of this Notice of Removal are being

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served on all counsel and filed with the Clerk of the Court, Northeast Division, of the State of Washington for King County.

10 As of the date of the filing of this Notice of Removal of Civil Action, 30 days have not elapsed from the time this matter first became removable Third-Party Defendant received service of Third-Party Summons and Complaint via the Insurance Commissioner for the State of Washington on or about April 8, 2002

11 Removal of the State Court Action from the King County District Court, Northeast Division, to this Court is proper

12 By filing this Notice of Removal, Third-Party Defendant does not waive, and it expressly reserves all rights, defenses, or objections of any nature that it may have to any and all claims

DATED this 2nd day of May, 2002

BULLIVANT HOUSER BAILEY PC

By _____
Medora A. Marisseau, WSBA # 23114
Heidi M. Eckel, WSBA #31596

Attorneys for Third-Party Defendant
Great-West Life & Annuity Ins. Co

3291471 1

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EXHIBIT A

IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY

IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION

Plaintiff/s

vs.

WALKER, JAMES F
WALKER, ELIIE
HIS WIFE

Defendant/s

Case # - Y1-24476

Summons (20 days)

TO THE DEFENDANT(S): A lawsuit has been started against you in the above entitled court by:

MERCHANTS CREDIT CORPORATION ,Plaintiff

Plaintiff's claim is stated in the written complaint, a copy of which is served upon you with this summons.

In order to defend against this lawsuit, you must respond to the complaint by stating your defense

LAW OFFICES OF ROBERT S. FRIEDMAN
2245 152ND Avenue NE, Redmond WA 98052
(425) 643-9520, FAX (425) 643-8546

in writing, serve a copy upon the person signing this summons within 20 days after the service of this summons, excluding the day of service, and file a copy with the court named above. If you do not, a default judgment may be entered against you without prior notice. A default judgment is one where plaintiff is entitled to what he/she asks for because you have not responded. If you serve a notice of appearance on the undersigned person, you are entitled to notice before a default judgment may be entered. A copy of all responsive pleadings must be filed with the court.

If you wish to seek the advice of an attorney in the matter, you should do so promptly so that your written response, if any, may be served and filed with the court on time.

This summons is issued pursuant to rule 4 of the Justice Court Civil Rules.

DATED: 07-18-01

ROBERT S. FRIEDMAN
WSB #1854
ATTORNEY FOR PLAINTIFF
2245 152ND AVE NE
REDMOND, WA 98052
425 643-9520

NORTHEAST DIVISION DISTRICT COURT
8601 160TH AVE NE
REDMOND WA 98052

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IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY

IN THE STATE OF WASHINGTON

- Y1-24476

MERCHANTS CREDIT CORPORATION	Case #
vs.	
WALKER, JAMES F WALKER, ELIIE HIS WIFE	Complaint
Defendant/s	

Complaint

Plaintiff alleges each account herein as a separate claim with Paragraphs 1 through 4 as to each claim :

1. The claim herein has been assigned to plaintiff for collection.

2. Plaintiff is a Washington corporation in good standing and is duly licensed and has satisfied the bonding requirement of the State of Washington.

3. Defendant/s are subject to the jurisdiction of this court.

4. During all material times defendants above were and are married and the obligation hereafter pleaded

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is the community and separate obligation of each.

Defendant/s became indebted to :

EVERGREEN HEALTHCARE

for certain goods and services, which the assignor is duly licensed to render, upon which there remains a balance of $17928.26, plus interest of $1980.38, which has been demanded without avail. Last charge : 02-29-00

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(425) 643-9520, FAX (425) 643-8546

WHEREFORE, Plaintiff prays judgment against the Defendant/s, and each of them, separately and for the marital community for $17928.26, plus interest of $1980.38, and for statutory court costs: attorney fee $125.00, filing fee $41.00, estimated process service fee $45.00; and reasonable attorney fees in the sum of $0.00, collection costs of $0.00, damages in the sum of $0.00, handling fees of $0.00, for a total of $20119.64.

DATED:07-18-01

ROBERT S. FRIEDMAN WSB #1854
ATTORNEY FOR PLAINTIFF

LAW OFFICES OF ROBERT S. FRIEDMAN
2245 152ND Avenue NE, Redmond WA 98052
(425) 643-9520, FAX (425) 643-8546

IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY
IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION vs. WALKER, JAMES F WALKER, ELIIE HIS WIFE Defendant/s	NO. - Y1-24476 NOTICE OF APPEARANCE BY DEFENDANTS

TO: The Plaintiff, through its attorney, Robert S. Friedman, 2245 152nd Avenue NE, Redmond, WA 98052.

AND TO: The Clerk of the Northeast Division District Court of King County.

YOU AND EACH OF YOU will please take notice that the Defendants hereby appear in the above-entitled action through the undersigned attorney, without waiving the questions of:

1. Lack of jurisdiction over the subject matter;
2. Lack of jurisdiction over the person;
3. Improper venue;
4. Insufficiency of process;

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1080 BROADACCESS BUILDING
1601 SECOND AVENUE
SEATTLE, WASHINGTON 98101
PHONE (206) 224-1650
FAX (206) 224-7011

5. Insufficiency of service of process;

6. Failure to state a claim upon which relief may be granted; and

7. Failure to join a party under Civil Rule 19.

You are hereby further notified that all future pleadings or papers, exclusive of original process, and all future orders, notices, etc., are to be served upon said attorney for the defendants at his address below stated.

DATED this 1st day of November, 2001.

BRENEMAN LAW FIRM

By _____
Scott C. Breneman
Attorney for Defendants
WSBA #18486

Breneman Law Firm
1080 Broadacres Building
1601 Second Avenue
Seattle, WA 98101
(206) 244-1650

BRENEMAN LAW FIRM
1080 BROADACRES BUILDING
1601 SECOND AVENUE
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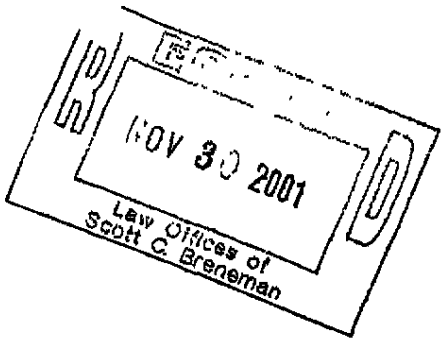

STATE OF WASHINGTON)
) ss
COUNTY OF KING)

The undersigned, being first duly sworn, on oath, states: That on this day affiant deposited in the mails of the United States of America a properly stamped and addressed envelope directed to the Attorney of record for Defendants containing a copy of the document to which this affidavit is attached. Certified true and correct under penalty of perjury of the laws of the State of Washington.

Dated,

11/29/01 J. Hathaway

IN KING COUNTY DISTRICT COURT, NORTHEAST DIVISION
STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION, Plaintiff, vs WALKER, JAMES F WALKER, ELIIE HIS WIFE Defendants.	NO. Y1-24476 NOTE FOR CIVIL MOTION DOCKET **(Clerk's Action Required)**

TO THE CLERK OF THE COURT:
AND TO: SCOTT C. BRENEMAN, ATTORNEY FOR DEFENDANT(S)
1080 BROADACRES BUILDING
1601 SECOND AVENUE
SEATTLE, WA 98101

Please note that the issue of law in this case will be heard on the date set out below and the clerk is requested to note the same on the motion docket for that day.

DATE OF HEARING:	**JANUARY 14th, 2002**
TIME OF HEARING:	**1:30PM**
NATURE OF MOTION:	**MOTION FOR DEFAULT JUDGMENT**
COURT ADDRESS:	NORTHEAST DIVISION DISTRICT COURT 8601 160TH AVE NE REDMOND, WA 98052

Dated: November 29th, 2001

Presented by:

LAW OFFICES OF ROBERT S. FRIEDMAN

ROBERT S. FRIEDMAN - WSBA #1854
Attorney for Plaintiff

LAW OFFICES OF ROBERT S. FRIEDMAN
2245 152nd Avenue NE, Redmond WA 98052
(425) 643-9520, FAX (425) 643-8546

STATE OF WASHINGTON)
(ss
COUNTY OF KING)

The undersigned being first duly sworn, on oath, states. That on this day affiant deposited in the mails of the United States of America a properly stamped and addressed envelope directed to the Attorney of record for/or Defendants containing a copy of the document to which the affidavit is attached. Certified true and correct under penalty of perjury of the laws of the State of Washington.

Dated:
11/29/01 J. Hathaway

IN KING COUNTY DISTRICT COURT, NORTHEAST DIVISION
STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION, Plaintiff,	NO. Y1-24476
vs	
WALKER, JAMES F WALKER, ELIIE HIS WIFE	MOTION AND AFFIDAVIT FOR ORDER OF DEFAULT
Defendant(s)	

COMES NOW the Plaintiff, by and through Robert S. Friedman, its attorney of record, and respectfully moves this court for entry of an Order adjudging Defendants, JAMES F. WALKER & ELIIE WALKER, to be in default herein. Defendant(s) above-named, through theri Attorney, SCOTT C. BRENEMAN, have filed an Appearance, but have filed no answer or other pleading and accordingly are in default. Should an Answer be filed prior to the hearing of this Motion, Plaintiff prays for the setting of a trial date by this Court.

LAW OFFICES OF ROBERT S. FRIEDMAN

ROBERT S. FRIEDMAN - WSBA #1854
Attorney for Plaintiff

State of Washington)ss
County of King)

The undersigned, being first duly sworn on oath states:

That I am the attorney for Plaintiff and make this Affidavit in support of the foregoing Motion. the Affidavit of service states that the Attorney, above-named was served, 10/17/01, with the Summons and Complaint and the Defendants, above-named, through their Attorney have filed an Appearance but no Answer or other pleading and are in default herein.

Certified true and correct under penalty of perjury of the laws of the State of Washington.

DATED at Redmond, Washington, November 29th, 2001

LAW OFFICES OF ROBERT S. FRIEDMAN

ROBERT S. FRIEDMAN - WSBA #1854
Attorney for Plaintiff

LAW OFFICES OF ROBERT S. FRIEDMAN
2245 152ND Avenue NE, Redmond WA 98052
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IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY
IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION,

Plaintiff,

v.

WALKER, JAMES F
WALKER, ELLIE
HIS WIFE,

Defendants;

JAMES F. WALKER and ELEANOR E. WALKER, husband and wife,

Third Party Plaintiffs,

v.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, a Colorado corporation,

Third party Defendant

NO. Y1-24476

SUMMONS
(20-DAY; 60 DAYS IF SERVED OUT OF STATE)

TO THE THIRD PARTY DEFENDANT: A lawsuit has been started against you, and claims asserted against you, in the above-entitled Court by the above-named Third Party

BRENEMAN LAW FIRM
1080 Broadacres Building
1601 Second Avenue
Seattle Washington 98101
Phone (206) 224-1650
Fax (206) 224-7011

Plaintiffs. Third Party Plaintiffs' claim is stated in the written Answer of Defendants, Affirmative Defenses and Third Party Complaint, a copy of which is served upon you with this Summons.

In order to defend against this lawsuit, you must respond to the Third Party Complaint by stating your defense in writing, and by serving a copy upon the undersigned attorney for the Third Party Plaintiffs within 20 days after the service of this Summons, excluding the day of service, if served within the State of Washington (or within 60 days after said service, if served out of the State of Washington), or a default judgment may be entered against you without notice. A default judgment is one where Third Party Plaintiffs are entitled to what they ask for because you have not responded. If you serve a notice of appearance on the undersigned attorney, you are entitled to notice before a default judgment may be entered.

You may demand that the Third Party Plaintiffs file this lawsuit with the Court. If you do so, the demand must be in writing and must be served upon the person signing this summons. Within 14 days after you serve the demand, the Third Party Plaintiffs must file this lawsuit with the Court, or the service on you of this Summons and Third Party Complaint will be void.

If you wish to seek the advice of an attorney in this matter, you should do so promptly so that your written response, if any, may be served on time.

This Summons is issued pursuant to Rule 4 of the Superior Court Civil Rules of the State of Washington.

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1601 Second Avenue
Seattle, Washington 98101
Phone (206) 224-1650
Fax (206) 224-7011

DATED this 11th day of January, 2002.

BRENEMAN LAW FIRM
By _____
Scott C. Breneman,
WSBA #18486
Attorney for Defendants and
Third Party Plaintiffs

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1080 Broadacres Building
1601 Second Avenue
Seattle Washington 98101
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Fax (206) 224-7011

IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY
IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION,

Plaintiff,

v.

WALKER, JAMES F
WALKER, ELLIE
HIS WIFE,

Defendants;

JAMES F. WALKER and ELEANOR E. WALKER, husband and wife,

Third Party Plaintiffs,

v.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, a Colorado corporation,

Third party Defendant

NO. Y1-24476

ANSWER OF DEFENDANTS, AFFIRMATIVE DEFENSES AND THIRD PARTY COMPLAINT

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Seattle, Washington 98101
Phone (206) 224-1650
Fax (206) 224-7011

COME NOW defendants JAMES F. WALKER and ELLIE WALKER, by and through their undersigned counsel, and hereby state their Answer, and set forth their Affirmative Defenses, to plaintiff's Complaint. Defendants also set forth their Third Party Complaint. The paragraph numbers in the Answer immediately below correspond to the paragraph numbers contained in plaintiff's Complaint.

ANSWER

1. Defendants are generally without knowledge or information sufficient to form a belief as to the truth of the allegations in this paragraph and therefore deny same.

2. Defendants are generally without knowledge or information sufficient to form a belief as to the truth of the allegations in this paragraph and therefore deny same.

3. Defendants, although denying plaintiff's claims, do not contest jurisdiction of this Court. Defendants, however, contest that venue in the Northeast Division of this District Court is correctly laid. Defendants demand that plaintiff cause this action to be transferred to, and venued in, the Seattle division of this District Court.

4. The phrase "[d]uring all material times" is too vague as to permit a response and defendants therefore deny the allegations in paragraph 4 as they relate to, or incorporate, such phrase. Defendants admit that they are married. Defendants deny the remaining allegations in paragraph 4, and specifically deny that they have any obligation or liability to plaintiff, Evergreen Healthcare, Evergreen Hospital Medical Center or King County.

Except as otherwise admitted, qualified or denied, defendants deny each and every other allegation, matter and thing in plaintiff's Complaint.

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AFFIRMATIVE DEFENSES

Defendants allege the following affirmative defenses. Defendants reserve the right to allege additional affirmative defenses learned through discovery.

5. Failure to state a claim for which relief can be granted.

6. Contributory negligence.

7. Estoppel.

8. Promissory estoppel.

9. Failure of consideration.

10. Laches.

11. Waiver.

12. Assumption of risk.

13. Unclean hands.

14. Fault of a nonparty.

15. Payment.

16. Acceptance of discount.

17. Improper venue.

18. Failure to join a party under Rule 19.

THIRD PARTY COMPLAINT

JAMES F. WALKER and ELEANOR E. WALKER, husband and wife, hereby state their Third Party Complaint.

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JURISDICTION AND PARTIES

19. At all times material hereto, Third Party Plaintiffs James F. Walker and Eleanor E. Walker ("Third Party Plaintiffs") have been husband and wife. Third Party Plaintiffs reside in Seattle, Washington.

20. Third Party Defendant Great-West Life & Annuity Insurance Company ("Great-West") is, on information and belief, a Colorado corporation. Great-West, transacts and, at all times material hereto, transacted business in the State of Washington.

21. At all times material hereto, Great-West has been engaged in the business of making contracts of insurance within the State of Washington. At all times material hereto, Great-West has been an "insurer" as defined in RCW 48 01 050. At all times material hereto, Great-West has been subject to regulation under RCW Title 48.

22. This Court has jurisdiction of this Third Party Complaint. This Court has jurisdiction over Great-West.

ALLEGATIONS

23. Third party plaintiffs incorporate paragraphs 1-22 as though fully set forth herein.

24. In February 2000, Third Party Plaintiff James F. Walker was an insured of Great-West. Mr. Walker was insured under a policy of health insurance issued by Great-West. Great-West and/or Great-West's agent administered such policy of health insurance. Great-West, and/or Great-West's agent, at all times material hereto did business under the name "Great West Life & Annuity Insurance Company" "One Health Plan" and/or "One Health Plan Medical Management".

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25. On February 14, 2000, Mr. Walker was admitted to Evergreen Hospital Medical Center in Kirkland, Washington ("Evergreen") for reasonable and necessary medical treatment and care. Such treatment and care included emergency services.

26. On February 22, 2000, Great-West certified in a letter to Mr. Walker that it had "evaluated" a service request and that it had certified "a 9 day length of stay at Evergreen Hospital Medical Cen [sic]." In other words, Great-West was certifying Mr. Walker's stay at Evergreen through February 23, 2000 (February 14, 2000, plus 9 days). Great-West further stated in such certification letter to Mr. Walker that it had sent "a letter with this information to (Mr. Walker's physician) and Evergreen Hospital Medical Cen [sic]".

27. On February 26, 2000, Great-West, certified in writing to Mr. Walker that it had "evaluated" a "request for the extension of inpatient stay at Evergreen Hospital Medical Cen [sic]" and that it had "certified the extension of stay for an additional 4 days" "for a total of 13 days". In other words, Great-West was certifying Mr. Walker's stay at Evergreen through February 27, 2000. (February 14, 2000, plus 13 days). Great-West further stated in such certification letter to Mr. Walker that it had sent "a letter with this information to (Mr. Walker's physician) and Evergreen Hospital Medical Cen [sic]."

28. On February 28, 2000, Great-West, certified in writing to Mr. Walker that it had "evaluated" a "request for the extension of inpatient stay at Evergreen Hospital Medical Cen" and that it had "certified the extension of stay for an additional 1 day" "for a total of 15 day [sic]". In other words, Great-West was certifying Mr. Walker's stay at Evergreen through February 29, 2000. (February 14, 2000, plus 15 days). Great-West further stated in such

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certification letter to Mr. Walker that it had sent "a letter with this information to (Mr. Walker's physician) and Evergreen Hospital Medical Cen".

29. Third Party Plaintiffs justifiably relied upon Great-West's certifications to their detriment. In justifiable reliance upon Great-West's certifications, Mr. Walker stayed at Evergreen and continued to receive care at Evergreen.

30. Despite the fact that Great-West had certified Mr. Walker's stay at Evergreen through February 29, 2000, on February 28, 2000 Evergreen abruptly and forcibly discharged Mr. Walker from Evergreen.

31. At no time during Mr. Walker's stay at Evergreen until the time of his discharge did either Evergreen or Great-West raise any question of, or dispute in any way, Great-West's coverage of Mr. Walker's stay and care at Evergreen.

32. On October 6, 2000, Third Party Plaintiffs, through their attorney, faxed and mailed to Great-West a letter in which Third Party Plaintiffs, among other things, (a) made a claim against Great-West regarding, and demanded that Great-West pay, a bill dated 6/29/00 from Evergreen in the amount of $17,963.65 relating to Mr. Walker's treatment at Evergreen for service dates 2/14/00-2/29/00; (b) demanded, if Great-West denied liability for such bill, that Great-West deliver in writing by the close of business on Friday, October 13, 2000 every reason upon which Great-West relied in denying coverage for such bill (i.e., the basis, if any, in the insurance policy in relation to the facts for denial of payment of such bill); and (c) demanded that Great-West provide a certified copy of Mr. Walker's complete policy with Great-West by the close of business on Friday, October 13, 2000. A copy of Evergreen's bill was enclosed with such claim dated October 6, 2000.

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Fax (206) 224-7011

33. On October 25, 2000, Great-West acknowledged receipt of the October 6, 2000 letter containing the Walker's claim.

Great-West failed to provide any written response to the claim of Third Party Plaintiffs dated October 6, 2000 until July 12, 2001. Great-West never paid the Evergreen bill. Great-West never provided a certified copy of Mr. Walker's complete policy with Great-West. Great-West failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under Mr. Walker's insurance policy.

34. Indemnity. Third Party Plaintiffs deny that they have any liability to plaintiff, Evergreen Healthcare, Evergreen Hospital Medical Center or King County. To the extent, however, that Third Party Plaintiffs are adjudged or otherwise found to be liable to plaintiff, Third Party Defendant Great-West is liable for any and all liability attributed or apportioned to Third Party Plaintiffs, and is liable to fully indemnify and hold Third Party Plaintiffs harmless therefor.

35. Breach of contract. Third Party Defendant Great-West has breached its contract of insurance with the Third Party Plaintiffs. Such breach has caused Third Party Plaintiffs damage.

36. Misrepresentation. Third Party Defendant Great-West misrepresented material facts to Third Party Plaintiffs. Third Party Defendant Great-West breached an affirmative duty to disclose a material fact or material facts to Third Party Plaintiffs. Such misrepresentation has caused Third Party Plaintiffs damage.

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37. Negligence. Third Party Defendant Great-West owed a duty to Third Party Plaintiffs. Third Party Defendant Great-West breached such duty, causing injury to Third Party Plaintiffs that was proximately caused by such breach.

38. Bad Faith. Third Party Defendant Great-West's conduct towards and regarding Third Party Plaintiffs was in bad faith.

39. Violation by Great-West of the Washington Statutes and Regulations Governing Insurance. Great-West failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under Mr. Walker's insurance policy. Great-West violated Washington law, including Washington Administrative Code ("WAC") sections WAC 284-30-330, including WAC 284-30-330(2), (5), and (13), and 284-30-380.

40. Violation by Great-West of the Washington Consumer Protection Act. The actions and inactions of Third Party Defendant Great-West violated the Washington Administrative Code and constituted a per se unfair trade practice in violation of the Washington Consumer Protection Act (RCW Ch. 19.86).

41 Estoppel. Third Party Defendant Great-West is estopped from denying insurance coverage to Third Party Plaintiffs regarding plaintiff's claims.

42. Promissory Estoppel. Third Party Plaintiffs justifiably relied upon the certifications, promises and representations of Third Party Defendant Great-West, all to the detriment and damage of Third Party Plaintiffs. Third Party Defendant Great-West is promissorily estopped from denying coverage to Third Party Plaintiffs regarding plaintiff's claims.

41. Negligent Infliction of Emotional Distress. Third Party Defendant Great-West committed the tort of negligent infliction of emotional distress.

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Phone (206) 224-1650
Fax (206) 224-7011

42. Third Party Plaintiffs have complied with all conditions for bringing and maintaining this lawsuit. Third Party Plaintiffs are entitled to treble damages, their attorneys' fees and costs under RCW Ch. 19.86, and under applicable Washington statutes, regulations and case law.

43. Third Party Plaintiffs reserve the right to add additional Third Party Defendants in this action, including Evergreen.

WHEREFORE, Third Party Plaintiffs request the following relief:

1. Judgment dismissing, with prejudice, Plaintiff's Complaint and all claims therein, without an award of attorneys' fees, costs or expenses to Plaintiff, but with an award of attorneys' fees, costs, and expenses incurred by defendants and Third Party Plaintiffs;

2. Judgment against the Third Party Defendant for Third Party Plaintiffs' actual damages in an amount to be determined at trial or otherwise,

3. Judgment against the Third Party Defendants, and each one of them, jointly and severally, for increased damages under RCW Ch. 19.86,

4. Judgment against the Plaintiff and Third Party Defendants, and each one of them, jointly and severally, for Defendants' and Third Party Plaintiffs' attorneys' fees;

5. Judgment against the Plaintiff and Third Party Defendants, and each one of them, jointly and severally, Third Party Plaintiffs' costs and disbursements;

6. For an Order allowing Third Party Plaintiffs additional costs and attorneys' fees incurred in connection with collection of such judgment, supplemental proceedings or in further proceedings;

7. Such other relief as the Court deems just and equitable.

BRENEMAN LAW FIRM
1080 Broadacres Building
1601 Second Avenue
Seattle, Washington 98101
Phone (206) 224-1650
Fax (206) 224-7011

DATED this 11th day of January, 2002.

BRENEMAN LAW FIRM
By _____
Scott C. Breneman,
WSBA #18486
Attorney for Defendants and
Third Party Plaintiffs

BRENEMAN LAW FIRM
1080 Broadacres Building
1601 Second Avenue
Seattle, Washington 98101
Phone (206) 224-1650
Fax (206) 224-7011

STATE OF WASHINGTON)
(SS
COUNTY OF KING)

The Undersigned being first duly sworn, on oath states That on this day affiant deposited in the mails of the United States of America a properly stamped and addressed envelope directed to the Attorney of Record or defendant Containing true and correct under penalty of perjury of the laws of the State of Washington.
Dated
4/4/02 J. Hathaway

RECEIVED
APR 08 2002
Law Offices of
Scott C Breneman

IN THE KING COUNTY DISTRICT COURT, NORTHEAST DIVISION
IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION,)
Plaintiff,)
)
vs)
WALKER, JAMES F)
WALKER, ELIIE)
HIS WIFE)
Defendant(s).)

NO. Y1-24476

NOTE FOR TRIAL SETTING
(CLERKS ACTION REQUIRED)

TO THE CLERK OF THE COURT:
AND TO: SCOTT C. BRENEMAN, ATTORNEY FOR DEFENDANT(S)
1080 BROADACRES BUILDING
1601 SECOND AVENUE
SEATTLE, WA 98101

Please take notice that this case is ready for trial date assignment.
Please state the following:

1. Nature of case: Collection of debt
2. Date Answer served: January 11th, 2002
3. A jury has not been demanded.
4. Estimated Trial time: 30 minutes

Dated: April 4th, 2002

LAW OFFICES OF ROBERT S. FRIEDMAN

ROBERT S. FRIEDMAN WSBA# 1854
Attorney for Plaintiff

Designated Court Dates:	Unacceptable Dates:
May 28th, 2002 at 1:30 PM	N/A
June 25th, 2002 at 1:30 PM	N/A

Note for Trial - 1

LAW OFFICES OF ROBERT S. FRIEDMAN
2245 152ND Avenue NE, Redmond WA 98052
(425) 643-9520, FAX (425) 643-8546

STATE OF WASHINGTON)
(ss
COUNTY OF KING)

The undersigned, being fully sworn, on oath, states: That on this day affiant deposited in the mails of the United States of America a properly stamped and addressed envelope directed to the Attorney of Record or Defendant containing a copy of the document to which this affidavit is attached, Certified true and correct under penalty of perjury of the laws of the State of Washington.

Dated:

4/4/02 G. Hathaway

IN THE KING COUNTY DISTRICT COURT, NORTHEAST DIVISION
IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION, Plaintiff,	NO. Y1-24476
	LCRJ 26 NOTICE
vs.	
WALKER, JAMES F WALKER, ELIIE HIS WIFE, Defendants.	

The attached documents are being presented to you pursuant to King County District Court Rules. Rule LCRLJ 26 provides that the enclosed documents will be presumed admissible and used as evidence in support of Plaintiff's case at the time of trial.

1 Itemized Statement(s)

2. Custodian: Collection / Credit Supervisor
Evergreen Healthcare
12040 NE 128th Street
Kirkland, WA 98034

3. Maker: Records Department / Same as above

Dated this 4th day of April, 2002.

LAW OFFICES OF ROBERT S. FRIEDMAN

ROBERT S. FRIEDMAN WSBA# 1854
Attorney for Plaintiff

LCRLJ 26 NOTICE - 2

LAW OFFICES OF ROBERT S. FRIEDMAN
2245 152ND Avenue NE, Redmond WA 98052
(425) 643-9520, FAX (425) 643-8546

12040 N.E. 128th STREET
KIRKLAND, WASHINGTON 98034

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

• Evergreen Hospital Medical Center • Evergreen Senior Health Centers • Evergreen Head Injury Re-Entry • Evergreen Surgical Center • Evergreen Home Health Services • Evergreen Hospice Services

PATIENT	TYPE CLAIM	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	0 07 ON01	1	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00

STAY	ACCOUNT NO.
15	5687387-01

GUARANTOR NO	AMOUNT PAID
536466490	

HISTORY NO	
4306951	$

FOR PROPER CREDIT, PLEASE ENCLOSE THIS TOP PORTION WITH PAYMENT.

EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1600

PATIENT	ACCOUNT NO.	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	1

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
02/14	000111		221001/MEDICAL/ONCOLOGY	1	650.00
02/15	000111		221001/MEDICAL/ONCOLOGY	1	650.00
02/16	000111		221001/MEDICAL/ONCOLOGY	1	650.00
02/17	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/18	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/19	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/20	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/21	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/22	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/23	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/24	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/25	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/26	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/27	000111		221801/MEDICAL/ONCOLOGY	1	650.00
02/28	000111		221801/MEDICAL/ONCOLOGY	1	650.00
	***120		ROOM-BOARD/SEMI		9,750.00
02/14	609760		DIAZEPAM 5MG/ML INJ	1	15.38
02/15	609761		DIAZEPAM 10MG/2ML INJ	1	15.38
02/15	613150		HYDROMORPHONE 2MG TUBEX	2	36.52
02/15	614590		LORAZEPAM 2MG TUBEX	1	38.09
02/15	614850		MAGNESIUM SULFATE 50% INJ 16MEQ 4ML	1	15.10
02/16	614590		LORAZEPAM 2MG TUBEX	5	190.45
02/17	614590		LORAZEPAM 2MG TUBEX	50	1,904.50
02/18	614590		LORAZEPAM 2MG TUBEX	58	2,209.22
02/18	614621		LORAZEPAM DRIP 20MG/10ML	10	322.60
02/18	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	3	45.78
02/19	614590		LORAZEPAM 2MG TUBEX	2	76.18
02/19	614621		LORAZEPAM DRIP 20MG/10ML	5	161.30
02/19	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	1	15.26
02/20	614621		LORAZEPAM DRIP 20MG/10ML	70	2,258.20
02/20	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	3	45.78

EVERGREEN HEALTHCARE

INSURANCE BENEFITS ASSIGNED

TAX IDENTIFICATION NUMBER 91-0844563
KEEP THIS DOCUMENT FOR INCOME TAX AND OTHER RECORDS

ANY SERVICE RENDERED BUT NOT INCLUDED ABOVE WILL BE BILLED AT A LATER DATE

AR-001 (10/99)

12040 N E 128th STREET
KIRKLAND, WASHINGTON 9803

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

• Evergreen Hospital Medical Center • Evergreen Senior Health Centers • Evergreen Head Injury Re-Entry • Evergreen Surgical Center • Evergreen Home Health Services • Evergreen Hospice Services

PATIENT	TYPE/CLASS	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	D 07 ON01	2	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00
STAY: 15	ACCOUNT NO: 5687387-01
GUARANTOR NO: 536466490	AMOUNT PAID
HISTORY NO: 4306951	$

FOR PROPER CREDIT, PLEASE ENCLOSE THIS TOP PORTION WITH PAYMENT.

EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1600

PATIENT	ACCOUNT NO.	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	2

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
02/21	614621		LORAZEPAM DRIP 20MG/10ML	30	967.80
02/21	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	2	30.52
02/22	614830		MAGNESIUM SULFATE 50% INJ 8MEQ 2ML	2	29.90
02/22	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	2	30.52
02/23	614621		LORAZEPAM DRIP 20MG/10ML	30	967.80
02/23	614870		MAGNESIUM SULFATE 50% INJ 5GM 10ML	1	32.38
02/23	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	3	45.78
02/24	614870		MAGNESIUM SULFATE 50% INJ 5GM 10ML	1	32.38
02/24	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	2	30.52
02/26	618460		POTASSIUM CHLORIDE 20MEQ/10ML INJ	1	15.26-
02/28	612580		HALOPERIDOL 5MG/ML INJ	3	44.70
	***250		PHARMACY		9,546.78
02/14	614650		LORAZEPAM 1MG TAB	4	14.36
02/14	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	4	14.24
02/14	621010		THIAMINE 100MG TAB	2	6.82
02/15	614650		LORAZEPAM 1MG TAB	2	7.18
02/15	614651		LORAZEPAM 2MG TAB	4	15.68
02/15	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/15	621010		THIAMINE 100MG TAB	1	3.41
02/16	612950		HYDROCORTISONE 0.5% CRM 1OZ	1	11.54
02/16	614651		LORAZEPAM 2MG TAB	6	23.52
02/16	614820		MAGNESIUM OXIDE 400MG TAB	3	10.62
02/16	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/17	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/17	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/18	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/18	616570		MUPIROCIN 2% OINT 15GM	1	29.98
02/18	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/19	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/19	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/20	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08

INSURANCE BENEFITS ASSIGNED

TAX IDENTIFICATION NUMBER 91-0844553
KEEP THIS DOCUMENT FOR INCOME TAX AND OTHER RECORDS

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AR-001 (10/99)

12040 N.E. 128th STREET
KIRKLAND, WASHINGTON 9803

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

• Evergreen Hospital Medical Center • Evergreen Senior Health Centers • Evergreen Head Injury Re-Entry • Evergreen Surgical Center • Evergreen Home Health Services • Evergreen Hospice Services

PATIENT	TYPE/CLASS	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	0 07 ON01	3	06/19/01

51 Y

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00
STAY: 15	ACCOUNT NO: 5687387-01
GUARANTOR NO: 536466490	AMOUNT PAID
HISTORY NO: 4306951	$

FOR PROPER CREDIT, PLEASE ENCLOSE THIS TOP PORTION WITH PAYMENT.

EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1600

PATIENT	ACCOUNT NO.	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	3

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
02/20	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/21	610380		DOCUSATE 240MG CAP	1	3.42
02/21	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/21	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/21	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/21	619710		SENNA TABLET	2	7.12
02/22	610380		DOCUSATE 240MG CAP	1	3.42
02/22	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/22	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/22	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/22	619710		SENNA TABLET	2	7.12
02/23	610380		DOCUSATE 240MG CAP	1	3.42
02/23	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/23	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/23	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/23	619710		SENNA TABLET	2	7.12
02/24	606130		ATENOLOL TAB 50MG	2	9.20
02/24	610380		DOCUSATE 240MG CAP	1	3.42
02/24	614650		LORAZEPAM 1MG TAB	1	3.59
02/24	614651		LORAZEPAM 2MG TAB	2	7.84
02/24	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/24	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/24	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/24	619710		SENNA TABLET	2	7.12
02/25	606130		ATENOLOL TAB 50MG	1	4.60
02/25	610380		DOCUSATE 240MG CAP	1	3.42
02/25	614651		LORAZEPAM 2MG TAB	17	66.64
02/25	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/25	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/25	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/25	619710		SENNA TABLET	2	7.12
02/26	606130		ATENOLOL TAB 50MG	1	4.60
02/26	610380		DOCUSATE 240MG CAP	1	3.42

INSURANCE BENEFITS ASSIGNED

TAX IDENTIFICATION NUMBER 91-0844563
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AR-001 (10/99)

12040 N.E. 128th STREET
KIRKLAND, WASHINGTON 98034

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

• Evergreen Hospital Medical Center • Evergreen Senior Health Centers • Evergreen Head Injury Re-Entry • Evergreen Surgical Center • Evergreen Home Health Services • Evergreen Hospice Services

PATIENT	TYPOUSB	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT. DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	D 07 ON01	4	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00
STAY: 15	ACCOUNT NO.: 5687387-01
GUARANTOR NO.: 536466490	AMOUNT PAID
HISTORY NO.: 4306951	$

FOR PROPER CREDIT, PLEASE ENCLOSE THIS TOP PORTION WITH PAYMENT.

EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1600

PATIENT	ACCOUNT NO.	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	4

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
02/26	614651		LORAZEPAM 2MG TAB	10	39.20
02/26	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/26	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/26	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/26	619710		SENNA TABLET	2	7.12
02/27	606130		ATENOLOL TAB 50MG	2	9.20
02/27	610380		DOCUSATE 240MG CAP	1	3.42
02/27	614651		LORAZEPAM 2MG TAB	18	70.56
02/27	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/27	616570		MUPIROCIN 2% OINT 15GM	2	59.96
02/27	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/27	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/27	619710		SENNA TABLET	2	7.12
02/28	606130		ATENOLOL TAB 50MG	1	4.60
02/28	610380		DOCUSATE 240MG CAP	1	3.42
02/28	614650		LORAZEPAM 1MG TAB	3	10.77
02/28	614651		LORAZEPAM 2MG TAB	14	54.88
02/28	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/28	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/28	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/28	619710		SENNA TABLET	2	7.12
02/29	606130		ATENOLOL TAB 50MG	1	4.60
02/29	610380		DOCUSATE 240MG CAP	1	3.42
02/29	614650		LORAZEPAM 1MG TAB	1	3.59
02/29	614651		LORAZEPAM 2MG TAB	11	43.12
02/29	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08
02/29	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	2	7.12
02/29	619320		PSYLLIUM/SUCROSE PKT	1	3.56
02/29	619710		SENNA TABLET	2	7.12
03/02	606130		ATENOLOL TAB 50MG	2	9.20-
03/02	614820		MAGNESIUM OXIDE 400MG TAB	2	7.08-
03/02	618400		POTASSIUM CHLORIDE 20MEQ POWDER PACK	4	14.24-
03/02	619320		PSYLLIUM/SUCROSE PKT	4	14.24-

INSURANCE BENEFITS ASSIGNED

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ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

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PATIENT	TYP/CLASS	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	0 07 ON01	5	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00
STAY: 15	ACCOUNT NO: 5687387-01
GUARANTOR NO.: 536466490	AMOUNT PAID
HISTORY NO.: 4306951	$

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EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1900

PATIENT	ACCOUNT NO.	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	5

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
03/02	619710		SENNA TABLET	8	28.48-
	***259		DRUGS/SELF ADMIN		786.80
02/15	628040		D5W IV 100ML	1	14.72
02/17	628040		D5W IV 100ML	1	14.72
02/18	628040		D5W IV 100ML	3	44.16
02/18	628200		D5W/0.45NS IV 1000ML	3	49.71
02/19	628040		D5W IV 100ML	1	14.72
02/19	628200		D5W/0.45NS IV 1000ML	1	16.57
02/20	628040		D5W IV 100ML	14	206.08
02/20	628200		D5W/0.45NS IV 1000ML	3	49.71
02/21	628040		D5W IV 100ML	6	88.32
02/21	628200		D5W/0.45NS IV 1000ML	2	33.14
02/22	628040		D5W IV 100ML	1	14.72
02/22	628200		D5W/0.45NS IV 1000ML	2	33.14
02/23	628030		D5W IV 50ML	1	14.72
02/23	628040		D5W IV 100ML	6	88.32
02/23	628200		D5W/0.45NS IV 1000ML	3	49.71
02/24	628030		D5W IV 50ML	1	14.72
02/24	628200		D5W/0.45NS IV 1000ML	2	33.14
02/26	628200		D5W/0.45NS IV 1000ML	1	16.57-
	***260		IV THERAPY		763.75
02/14	227603		CS -CATHETER ABBOCATH	2	36.80
02/14	240705		CS -DRESSING TEGADERM	1	2.20
02/14	247446		CS -INJECTION SITE TRAVENOL	2	14.60
02/14	263430		CS -SET EXTENSION 6"	2	23.40
02/29	256552		CS -PADS ABSORBENT	2	4.40
	***270		MED-SURG SUPPLIES		81.40

EVERGREEN HEALTHCARE

INSURANCE BENEFITS ASSIGNED

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AR-001 (10/99)

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KIRKLAND, WASHINGTON 9802

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

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PATIENT	TYPE CLAIM	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	51 Y D 07 ON01	6	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

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IF YOU HAVE ANY QUESTIONS CALL (425) 899-1600

PATIENT	ACCOUNT NO.	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	6

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
02/14	315230	85025	CBC W/AUTO DIFFERENTIAL (LAB)	1	51.35
02/14	326710		COMPREHENSIVE METABOLIC PANEL (LAB)	1	76.00
02/14	327690		HEPATIC PROFILE (LAB)	1	92.95
02/14	328203	83735	MAGNESIUM (LAB)	1	50.56
02/14	359100	85610	PROTHROMBIN (LAB)	1	26.25
02/15	326731	80049	BASIC METABOLIC PANEL OP	1	23.50
02/15	328229	83735	LAB MAGNESIUM OP	1	18.00
02/15	356410	36415	LAB VENIPUNCTURE OP	1	10.50
02/16	326730		BASIC METABOLIC PANEL (LAB)	1	47.00
02/16	328203	83735	MAGNESIUM (LAB)	1	50.56
02/16	356402	36415	VENIPUNCTURE (LAB)	1	29.65
02/17	326530	82248	BILIRUBIN (DIRECT) (LAB)	1	26.40
02/17	328203	83735	MAGNESIUM (LAB)	1	50.56
02/17	356402	36415	VENIPUNCTURE (LAB)	1	29.65
02/21	326645		LAB CALCIUM OP	1	10.00
02/21	326731	80049	BASIC METABOLIC PANEL OP	1	23.50
02/21	328229	83735	LAB MAGNESIUM OP	1	18.00
02/21	328807	84100	LAB PHOSPHORUS OP	1	10.00
02/21	356410	36415	LAB VENIPUNCTURE OP	1	10.50
02/22	326730		*/	1	47.00
02/22	326731	80049	BASIC METABOLIC PANEL OP	1	23.50
02/22	328203	83735	MAGNESIUM (LAB)	1	50.56
02/22	356402	36415	VENIPUNCTURE (LAB)	1	29.65
02/22	356410	36415	LAB VENIPUNCTURE OP	1	10.50
02/23	328229	83735	LAB MAGNESIUM OP	1	18.00
	***300		LABORATORY		834.14
02/17	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	1	37.30
02/17	686014	97530	THERAPEUTIC ACTIVITIES	2	74.60
02/17	687012		EVALUATION WITH REPORT - 15 MIN	1	37.30
02/18	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/18	686014	97530	THERAPEUTIC ACTIVITIES	2	74.60

INSURANCE BENEFITS ASSIGNED

TAX IDENTIFICATION NUMBER 91 0844563
KEEP THIS DOCUMENT FOR INCOME TAX AND OTHER RECORDS

ANY SERVICE RENDERED BUT NOT INCLUDED ABOVE WILL BE BILLED AT A LATER DATE

AR-001 (10/99)

12040 N.E. 128th STREET
KIRKLAND, WASHINGTON 980

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

• Evergreen Hospital Medical Center • Evergreen Senior Health Centers • Evergreen Head Injury Re-Entry • Evergreen Surgical Center • Evergreen Home Health Services • Evergreen Hospice Services

PATIENT	TYPE/CLASS	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	0 07 ON01	7	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00

STAY	ACCOUNT NO.
15	5687387-01

GUARANTOR NO	AMOUNT PAID
536466490	

HISTORY NO.	
4306951	$

FOR PROPER CREDIT, PLEASE ENCLOSE THIS TOP PORTION WITH PAYMENT.

EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1600

PATIENT	ACCOUNT NO	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	7

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
02/19	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/20	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/21	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/22	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/24	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/25	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	1	37.30
02/25	686014	97530	THERAPEUTIC ACTIVITIES	4	149.20
02/26	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	2	74.60
02/26	686014	97530	THERAPEUTIC ACTIVITIES	2	74.60
02/27	681163	97116	GAIT TRAINING - 15 MIN	1	37.30
02/28	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	1	37.30
02/28	681163	97116	GAIT TRAINING - 15 MIN	1	37.30
02/28	686014	97530	THERAPEUTIC ACTIVITIES	2	74.60
02/29	681106	97110	THERAPEUTIC EXERCISE - 15 MIN	1	37.30
02/29	681163	97116	GAIT TRAINING - 15 MIN	1	37.30
02/29	686014	97530	THERAPEUTIC ACTIVITIES	2	74.60
	***420		PHYSICAL THERAPY		1,342.80
02/14	721205	99285	ED LEVEL 5	1	788.00
	***450		EMERGENCY ROOM		788.00
02/14	960080	99285	DR - LEVEL 5 PHYSICIAN EVALUATION	1	235.92
	***960		PRO FEES/DR. PILCHER		235.92
			TOTAL CHARGES		24,129.59
03/17	9202		GR.WEST/ONE HLTH CA		35.39-
03/28	9202		GR.WEST/ONE HLTH CA		3,584.06-

INSURANCE BENEFITS ASSIGNED

TAX IDENTIFICATION NUMBER 91-0844563
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AR-001 (10/99)

12040 N.E. 128th STREET
KIRKLAND, WASHINGTON 9803

ITEMIZED STATEMENT

EVERGREEN HEALTHCARE

• Evergreen Hospital Medical Center • Evergreen Senior Health Centers • Evergreen Head Injury Re-Entry • Evergreen Surgical Center • Evergreen Home Health Services • Evergreen Hospice Services

PATIENT	PT/VC/CLASS	SERVICE FROM	THROUGH	TYPE OF BILL	PAGE	STMT. DATE
JAMES F WALKER	I/C	02/14/00	02/29/00	0 07 ON01	8	06/19/01

RESPONSIBLE PARTY

JAMES F WALKER
7003 34TH NW
SEATTLE, WA 98117

ADMIT DATE	DISCHARGE DATE
02/14/00	02/29/00
STAY: 15	ACCOUNT NO.: 5687387-01
GUARANTOR NO.: 536466490	AMOUNT PAID
HISTORY NO: 4306951	$

FOR PROPER CREDIT, PLEASE ENCLOSE THIS TOP PORTION WITH PAYMENT.

EVERGREEN HEALTHCARE

IF YOU HAVE ANY QUESTIONS CALL (425) 899-1900

PATIENT	ACCOUNT NO	SERVICE FROM	THROUGH	PAGE
JAMES F WALKER	5687387-01	02/14/00	02/29/00	8

DATE	ITEM#	HCPCS	DESCRIPTION	QTY	AMOUNT
			TOTAL ADJUSTMENTS		3,619.45-
03/28	9702		GR.WEST/ONE HLTH PMT		4,842.40-
			TOTAL PAYMENTS		4,842.40-
03/30	9202		GR.WEST/ONE HLTH CA		2,260.52
08/10	0096		TRAN TO BAD DEBT		17,928.26-
			TOTAL ADJUSTMENTS		15,667.74-
			*** TOTAL		.00

EVERGREEN

INSURANCE BENEFITS ASSIGNED

TAX IDENTIFICATION NUMBER 91-0844563
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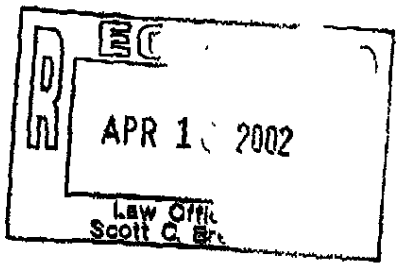
AR-001 (10/99)



IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY
IN THE STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION, Plaintiff, v. WALKER, JAMES F WALKER, ELLIE HIS WIFE, Defendants; JAMES F. WALKER and ELEANOR E. WALKER, husband and wife, Third Party Plaintiffs, v. GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, a Colorado Corporation, Third Party Defendant	**NO. Y1-24476** **INSURANCE COMMISSIONER'S CERTIFICATE OF SERVICE**

THIS IS TO CERTIFY that the Insurance Commissioner of the State of Washington has accepted service of

Summons, Answer to Defendants Afirmative Defenses, & Third Party Complaint

in the above-mentioned matter on April 8, 2002, on behalf of and as statutory attorney for

Great West Life & Annuity Insurance Company

an authorized foreign or alien insurer, and has forwarded a duplicate copy thereof to said insurance company pursuant to RCW 48.05.200 and 48.05.210.

Receipt of the $10 statutory service fee is acknowledged.

ISSUED AT OLYMPIA, WASHINGTON: April 9, 2002

Mike Kreidler
Insurance Commissioner

Certification No.: 107,345

By
Jennifer Bergin
Service of Process Coordinator

Original to:

Breneman Law Firm
1080 Broadacres Building
1601 Second Avenue
Seattle WA 98101

Copy to:

Great West Life & Annuity Insurance Company
Ruth B Lurie
8515 E Orchard Road
Englewood CO 80111

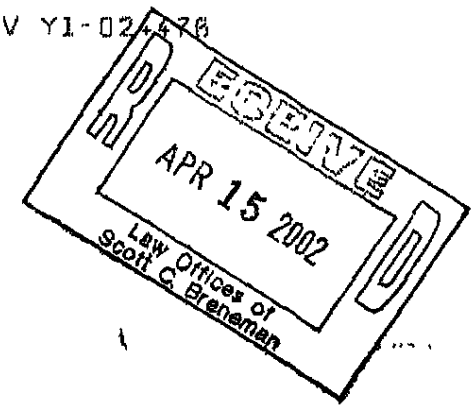
NORTHEAST DISTRICT COURT
8601 160TH AVE NE
REDMOND WA 98052
2062963667

April 11, 2002

MERCHANTS CREDIT ASSOCIATION
VS.
WALKER, JAMES F.

Cause No. CV Y1-02[illegible]

TO: BRENEMAN, SCOTT C.
1601 2ND AVE #1080
SEATTLE WA 98101



Notice of Civil Hearing

You are hereby notified that the above referenced cause has been set for: May 28, 2002 at 01:30 PM
for NON-JURY TRIAL CIVIL
Before Judge ADMIRE, DAVID S

BY: NORTHEAST DISTRICT COURT
CXU

IN THE NORTHEAST DIVISION DISTRICT COURT OF KING COUNTY,
STATE OF WASHINGTON

MERCHANTS CREDIT CORPORATION, Plaintiff, v. JAMES F. WALKER and ELLIE WALKER, his wife, Defendants.	No. Y1-24476 NOTICE OF APPEARANCE
JAMES F. WALKER and ELEANOR E WALKER, husband and wife, Third-Party Plaintiffs, v. GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, a Colorado corporation, Third-Party Defendant.	

TO : THE CLERK OF THE COURT;
AND TO : All Parties of Record.

YOU AND EACH OF YOU WILL PLEASE TAKE NOTICE that Medora A. Marisseau and Heidi M. Eckel, of Bullivant Houser Bailey, hereby appears on behalf of Third-Party Defendant Great-West Life & Annuity Insurance Company in the above-entitled cause by the undersigned attorneys and request that all further papers and pleadings herein, except

Bullivant|Houser|Bailey PC
2400 Westlake Office Tower
1601 Fifth Avenue
Seattle, WA 98101-1618
Telephone: (206) 292-8930

process, be served upon the undersigned attorneys at the address below stated.

DATED this 30th day of April, 2002.

BULLIVANT HOUSER BAILEY PC

By _____
Medora A. Marisseau, WSBA # 23114
Heidi M. Eckel, WSBA #31596

Attorneys for Third-Party Defendant Great-West Life & Annuity Ins. Co.

CERTIFICATE OF SERVICE

I certify under penalty of perjury under the laws of the State of Washington that on this day I caused to be delivered via messenger a copy of this document to all counsel of record

_____

Dated 4/30/02 at Seattle, Washington.

3291409 1

Bullivant|Houser|Bailey PC
2400 Westlake Office Tower
1601 Fifth Avenue
Seattle, WA 98101-1618
Telephone: (206) 292-8930

EXHIBIT B

Where To Find The Answers To Your Questions

INTRODUCTION

- **About This Plan**
  - Plan Administrator's Authority 1
  - Plan Modification/Termination 1
- **California Guarantee Association Act** 2
- **California Guarantee Association Act - Notice of Non-Coverage** 4
- **Continuity of Coverage Provision for Employees in California**
  - Exceptions to the Definition of Late Applicant - Special Enrollee 6
  - Pre-Existing Conditions 8

About This Plan

As of NOVEMBER 1, 1989, PUGET SOUND FREIGHT LINES, INC. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The benefits described in this booklet constitute the benefits available under the plan and are referred to collectively in this booklet as the "Employer's Plan." The Employer's Plan will be maintained pursuant to the terms of this booklet. The Employer's Plan may be amended from time to time. All prior plans established or maintained by the Employer are hereby revoked.

The benefits that form a part of the Employer's Plan and that are described in this booklet are self-funded by the Employer.

Under the terms of a Group Stop Loss Contract between the Employer and Great-West Life & Annuity Insurance Company, Great-West agrees to reimburse the Employer when claims reach a specified level.

Your Employer is fully responsible for the self-funded benefits. Great-West Life & Annuity Insurance Company (Great-West) processes claims and provides other services to your Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

The address of Great-West is 8505 E Orchard Road, Englewood, CO 80111

■ Plan Administrator's Authority

For self-funded benefits, the Plan Administrator has complete authority to control and manage the Employer's Plan and has full discretion to determine eligibility, to interpret the Employer's Plan and to determine whether a claim should be paid or denied, according to the provisions of the Employer's Plan as set forth in this booklet.

■ Plan Modification/Termination

The Employer intends to provide benefits under the Plan indefinitely. However, the Employer may at any time.

- change the contributions you must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If your Employer, through its acting management, decides that the Plan benefits should be amended or the Plan terminated for any reason, a designated representative of the Employer will prepare a written notice approved and signed by the Plan Administrator or any other person to whom the Employer gives authority to amend or terminate Plan benefits. The notice will be given to you within the time allowed by federal law. Your Plan Administrator can tell you who is responsible for approving Plan amendments or a Plan termination and the time in which notice of amendments or termination must be provided to you.

If the Plan is amended or terminated it will not affect the payment of any claims for expenses incurred prior to the time the change is made.

California Guarantee Association Act

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write this type of insurance are members of the California Life and Health Insurance Guarantee Association (CLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the California Health Insurance Guarantee Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.

Policyholders with additional questions should first contact their insurer or agent, and may then contact:

California Life and Health Insurance Guarantee Association
P O. Box 17319
Beverly Hills, CA 90209-3319

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the right or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract.
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals.
- Employer and association plans, to the extent they are self-funded or uninsured
- Synthetic guaranteed interest contracts.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields that exceed an average rate.
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNTS OF COVERAGE

The Act limits the Association to pay benefits as follows.

- for Life and Annuity Benefits:
  - 80% of what the life insurance company would owe under a life policy or annuity contract up to:
    * $100,000 in cash surrender values;
    * $100,000 in present value of annuities; or
    * $250,000 in life insurance death benefits.
  - A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.
- for Health Benefits, a maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for insurance policies to which the Act applies.

California Guarantee Association Act - Notice of Non-Coverage

Any benefits self-funded by an Employer

are NOT covered by

The California Life and Health Insurance Guarantee Association

EXCLUSIONS FROM COVERAGE

The following are not covered by the California Life and Health Insurance Guarantee Association.

- Unallocated annuity contracts, that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals.
- Employer and association plans, to the extent they are self-funded or uninsured
- Synthetic guaranteed interest contracts.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields that exceed an average rate.
- Any portion of a contract that provides dividends or experience rating credits

A determination as to whether an insurance contract is covered under the Guarantee Association or whether an annuity contract is allocated or unallocated must initially be made by the insurer based on its knowledge of the specific contract offered.

Also, you are not protected by this Association if:

- The insurer was not authorized to do business in this state when it issued the policy or contract.
- The policy is issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- You are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.

If you have questions concerning this Notice, you may contact:

California Life and Health Insurance Guarantee Association
P O. Box 17319
Beverly Hills, CA 90209-3319
(213) 782-0182

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

Questions as to specific policies or annuities should be directed to the insurance company offering the product.

Continuity of Coverage Provision for Employees in California

The benefits which are described in this provision:

- Will be subject to all other parts of this Plan except as specifically stated in this Provision.
- Are for the purpose of compliance with the law of the state of California.

■ Exceptions to the Definition of Late Applicant - Special Enrollee

For medical and prescription drug under this Plan:

- A person (you or your Dependent) will *not* be considered a late applicant and you may apply for coverage for such person under this Plan if you:
  - Did not apply for coverage for the person within 31 days of the date you became eligible to do so because the person was covered under another health insurance plan or arrangement (other plan); and
  - Certified in writing, when you were first eligible, that you declined coverage under this Plan because of coverage under the other plan, and
  - Lost coverage under the other plan as a result of:

  * Exhausting the maximum period of COBRA coverage; or
  * Loss of eligibility for the other plan's coverage due to legal separation, divorce or death of a spouse; or
  * Termination of employment or reduction in the number of hours of employment; or
  * Termination of the employer's contribution for the other plan's coverage;

  and

  - Request coverage under this Plan within 30 days of the date coverage is lost under the other plan.

  If you apply within 30 days after the date coverage is lost under the other plan, then coverage under this Plan will start on the day after the date the person's coverage terminated under the other plan

- A Dependent will ***not*** be considered a late applicant and you may apply for coverage for your Dependent under this Plan if you did not apply to cover such Dependent within 31 days of the date you became eligible to do so and later are required by a court order to provide coverage for your spouse or a minor child.

  If you apply within 30 days after the date on which the court order was issued, then coverage under this Plan will start on the day after the date the court order was issued.

If:

- You declined coverage for you or your Dependents when you first became eligible; and
- You acknowledged in writing that the Employer notified you that you or your Dependents who did not elect the coverage, would be considered a late enrollee;

but

- The Employer is unable to produce the written statement;

then you will not be considered a late applicant and your coverage under this Plan will start on the date on which you apply.

■ Pre-Existing Conditions

A pre-existing condition is an Illness or any related condition for which you or a Dependent received services, supplies or medication during the 3 months before coverage for you or your Dependent became effective under this medical Plan.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received after you or your Dependent.

- Has not received services, supplies or medication for this condition for 3 months; or
- Has been covered under this Plan for 6 months.

For Persons Covered under a Prior Plan

The Pre-Existing Conditions Limitation will not apply to expenses incurred by you or your Dependents if:

- Your Service begins after the effective date of this Plan; and
- You and your Dependents were covered under another "Qualifying prior coverage" (the prior plan), and
- The coverage under the prior plan terminated within the 31-day period just before you became eligible under this Plan; and
- The pre-existing condition was not excluded from coverage under the prior plan.

Any eligibility waiting period that you are required to satisfy under this Plan will not be taken into consideration in determining whether the coverage under the prior policy/plan terminated within 31 days just prior to the date on which you enrolled or became eligible to enroll for the coverage provided under this Plan.

The term "Qualifying prior coverage" will include·

- Any individual or group policy or plan not designed to supplement other private or governmental plans;
- Medicare,
- The Medicaid program pursuant to Title XIX of the Social Security Act; and
- Any other publicly sponsored program.

However, if the periods referred to in the Pre-Existing Conditions Limitation provision have been partially satisfied under the prior plan, these periods will be reduced by the number of consecutive months the person was covered under the prior plan just prior to the effective date of this Plan

It will be the covered person's responsibility to provide information about his or her coverage under the prior plan in order for the Pre-Existing Conditions Limitation period under this Plan to be reduced.

If you lose your health coverage because.

- Your employment terminated; or
- Your previous employer terminated his contribution towards your health coverage;

Then you will be eligible to receive credit for the periods referred to in this provision, if the coverage under the prior plan terminated within the 180-day period just before you became eligible under this Plan

Where To Find The Answers To Your Questions

WHEN COVERAGE BEGINS & ENDS

- **Who Is Eligible for Coverage?** 1
- **When Will My Coverage Begin?** 1
- **When Will My Dependent Coverage Begin?**
  - How Do I Add a New Dependent? 2
  - What If I Adopt a Child? 2
- **What If I Don't Apply For Coverage When I'm First Eligible?**
  - Exceptions to the Definition of Late Applicant - Special Enrollee 3
- **How Is My Health Coverage Affected When Claims Are Transferred to Great-West?** 4
- **Will My Coverage Change While I'm Covered Under This Plan?**
  - When Will The Change In My Coverage Take Place? 5
  - What If I Am Not Actively At Work When My Coverage Changes? 5
- **When Will Coverage under This Plan End?**
  - Employee Coverage 5
  - Dependent Coverage 6
- **Can I Continue Benefits If I Become Ineligible for Coverage under This Plan?**
  - Continuation Coverage 6
  - Continuation of Medical, Prescription Drug, Dental and Vision Coverage under COBRA 7
  - Extended Benefits 9
- **Can I Convert My Coverage to Another Plan?**
  - Conversion of Medical Benefits 10

WHEN COVERAGE BEGINS & ENDS *(cont'd)*

■ **What Happens to My Coverage If I'm a Military Reservist and I'm Called to Active Duty?**

If You Return to Work..... 12

Who Is Eligible for Coverage?

To be eligible for coverage for yourself and your Dependents under your Employer's Plan you must:

- Be a resident of the United States or Puerto Rico
- Not be a temporary Employee
- Be a full-time Employee who works at least:
  - for Office Employees, 30.00 hours per week;
  - for all Hourly Employees, 80 hours per month.
- Complete 120 days of continuous Service with your Employer

When Will My Coverage Begin?

This Plan went into effect on APRIL 1, 1994.

Your coverage begins on that date if you were eligible on that date.

If you become eligible after APRIL 1, 1994, your coverage will begin on the first day of the month coinciding with or next following the date you complete 120 days of continuous Service with your Employer.

For coverage to start on the date described above, you must.

- Fill out an application and give it to your Employer within 31 days of the date you become eligible; and
- Pay the required contribution, if any.

If you do not apply for coverage within 31 days of the date you become eligible, you will be considered a late applicant. (See "What If I Don't Apply For Coverage When I'm First Eligible?".)

When Will My Dependent Coverage Begin?

If you want to cover any Dependents under this Plan, be sure to include them when filling out your application.

Your Dependent coverage will begin when your coverage begins unless you do not apply for Dependent coverage within 31 days of the date you become eligible. In this case, your Dependents will be considered late applicants. (See "What If I Don't Apply For Coverage When I'm First Eligible?".)

How Do I Add a New Dependent?

If you already have Dependent coverage, any new Dependents will be covered automatically upon completion of a new application.

If you don't have Dependent coverage and acquire a new Dependent, you may apply for Dependent coverage. If you apply for Dependent coverage within 31 days of the date you acquired the new Dependent, coverage for that new Dependent will begin on the date you acquired the Dependent.

If you have other Dependents who were previously not covered and you wish to cover them, they may be considered late applicants. (See "What If I Don't Apply For Coverage When I'm First Eligible?".)

What If I Adopt a Child?

Coverage will be provided under this Plan for any child placed with you for adoption. The coverage will be subject to the following conditions:

For Contributory Plans

If you must contribute to the cost of your Dependent's coverage, then you must:

- Apply for the coverage in writing; and
- Make the required contribution.

If you do so:

- Within 31 days of the child's date of placement, coverage for the child will start:
  - For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth of the child; and
  - For any other adoptive child, from the date of placement.
- More than 31 days from the child's date of placement, then the child may be considered a late applicant. (See "What If I Don't Apply For Coverage When I'm First Eligible?".)

"Date of placement" means the date you assume and retain a legal obligation for total or partial support of a child in anticipation of the adoption of that child.

Pre-Existing Conditions Limitation

Any Pre-Existing Conditions Limitation described elsewhere in this booklet will *not* be applied to the coverage of a child placed with you for adoption.

Termination of Coverage for Adoptive Children

Your adoptive Dependent child's coverage will end on the earlier of these dates:

- The date on which the petition for adoption is dismissed or denied.

- The date on which the placement is disrupted prior to legal adoption and the child is removed from placement.

What If I Don't Apply For Coverage When I'm First Eligible?

A person (you or your Dependent) will be considered a late applicant under this Plan if:

- You have to make a contribution and don't apply for coverage within 31 days of the date you become eligible to cover that person; or
- You do not have to make a contribution but elect not to cover that person,

and you later want coverage for that person.

Late applicants can apply for coverage under this Plan.

For Medical, Prescription Drug, Dental and Vision Benefits, a late applicant may apply for coverage only during an Open Enrollment Period. Your Plan Administrator can tell you when the Open Enrollment Period begins and ends. Coverage for a late applicant who applies for coverage during the Open Enrollment Period will begin on the first day of the month following the close of the Open Enrollment period.

Medical Benefits will be subject to special limitations for pre-existing conditions. See the Pre-Existing Conditions Limitation described in the Medical Benefits section(s) of this Plan.

For Dental Benefits, a late applicant will be subject to "Limitations for Late Applicants" in the Dental Benefits section(s).

■ Exceptions to the Definition of Late Applicant - Special Enrollee

For Medical, Prescription Drug, Dental and Vision coverage under this Plan, a person (you or your Dependent) will ***not*** be considered a late applicant if:

- You did not apply for coverage for the person within 31 days of the date you became eligible to do so because the person was covered under another health insurance plan or arrangement (other plan); and coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce or death of a spouse; or
  - Termination of employment or reduction in the number of hours of employment, or

- Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply to cover yourself and any of your eligible Dependents.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the date specified in the court order.
- You acquire a new Dependent, coverage will start:
  - In the case of marriage, on the date of marriage
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

How Is My Health Coverage Affected When Claims Are Transferred to Great-West?

A person who was covered for similar health benefits under the Employer's prior plan on the date of its termination will become covered for health benefits under this Plan as of its effective date. "Health benefits" mean medical, prescription drug, dental and vision benefits.

If a person was on COBRA or any other continuation coverage or extension of benefits under the prior plan coverage will be provided for that person until the earlier of the following dates:

- The date on which coverage would end under the terms of this Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

For a person who was covered under any extension of benefits under the prior plan, the benefits provided will be the same as those provided by the prior plan, less any amount paid under that plan.

Any waiting periods under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan.

See each benefit section later in this booklet for additional information about how benefits will be affected by the transfer.

Will My Coverage Change While I'm Covered Under This Plan?

Your Employer may choose to amend this Plan. If the amounts or benefits provided are changed, your coverage will also change

■ When Will The Change In My Coverage Take Place?

- If the Plan is amended, changes will take place on the effective date of the amendment.

■ What If I Am Not Actively At Work When My Coverage Changes?

If you are not Actively at Work when either of these events occurs, the change in your coverage will not take place until you return to work with the Employer for one full day.

Similarly, if one of your covered Dependents is confined in the Hospital on the date of the change, that Dependent's coverage will not change until he or she is released from the Hospital. For all other Dependents, however, the change in coverage will take place on the date of the change.

All claims will be based on the benefits in effect on the date the claim was incurred.

When Will Coverage under This Plan End?

■ Employee Coverage

Your coverage will end on the earliest of the following dates:

- The date your Employer terminates the benefits described in this booklet
- The due date of the first contribution toward your coverage that you or your Employer fails to make.
- The date you are no longer eligible.
- The last day of the month coinciding with or next following the date your Service ends.

■ Dependent Coverage

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends, or
- The due date of the first contribution toward your Dependent coverage that you or your Employer fails to make; or
- The date your Dependent is no longer eligible for benefits

Can I Continue Benefits If I Become Ineligible for Coverage under This Plan?

You may be able to continue certain benefits even if you would otherwise become ineligible for coverage under this Plan.

These are the categories of coverage available.

- Continuation Coverage - You receive the same benefits you were entitled to as an Employee at the same cost to you, if any.
- Coverage under COBRA - If you elect this coverage, you receive the same health benefits you were entitled to as an Employee, but you will be responsible for paying the COBRA premium.
- Extended Benefits - Someone who is Totally Disabled receives limited health benefits at no cost.

■ Continuation Coverage

With continuation coverage, the same benefits you were entitled to as an Employee will continue at the same cost to you, if any.

If you become ineligible because your Service terminates for one of the following reasons, you will receive continuation coverage:

- Illness;
- Leave of absence;
- Temporary layoff.

The following chart shows the length of time certain benefits are available under continuation coverage.

Length of Time Continuation Coverage Provides Benefits	
Loss of Coverage Due to Illness	
Medical, Prescription Drug, Dental and Vision Benefits	90 days after the date your Service terminated.

Length of Time Continuation Coverage Provides Benefits *(Continued)*	
Loss of Coverage Due To Leave of Absence	
Medical, Prescription Drug, Dental and Vision Benefits	31 days after the date your Service terminated

Your continuation coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

Continuation of Coverage During Family and Medical Care Leave

If your Employer approves your Family and Medical Care Leave, coverage under this Plan will be continued for you and your eligible Dependents during your leave, provided that any required contributions are paid by you and/or your Employer.

If you do not pay your contributions while you are on Family and Medical Care Leave, coverage for you and your eligible Dependents will be discontinued. However, on the date you return to work, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her eligible Dependents on that date.

If you are on Family and Medical Care Leave on the effective date of this Plan and were covered under the prior plan sponsored by the Employer on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.

Your Employer may refuse to grant a Family and Medical Care Leave request under certain circumstances.

Should you have any questions about Family and Medical Care Leave, see your Plan Administrator for details.

■ Continuation of Medical, Prescription Drug, Dental and Vision Coverage under COBRA

If you become ineligible for coverage, you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Qualifying events determine if you are eligible for COBRA coverage. These qualifying events are listed in the chart below, along with the length of time that COBRA coverage is available.

Continuation of Coverage under COBRA	
Employee Medical, Prescription Drug, Dental and Vision Benefits	
Qualifying Event	Length of Time COBRA Coverage Is Available
• Termination of employment (unless due to gross misconduct) or reduction in your work hours	18 months (29 months if you or any covered Dependent qualifies for Social Security disability benefits due to a disability that existed on the date of the Qualifying Event or began within the first 60 days of COBRA coverage
Dependent Medical, Prescription Drug, Dental and Vision Benefits	
Qualifying Event	Length of Time COBRA Coverage Is Available
• Termination of your employment (unless due to gross misconduct) or reduction in your work hours	18 months (29 months if you or any covered Dependent qualifies for Social Security disability benefits due to a disability that existed on the date of the Qualifying Event or began within the first 60 days of COBRA coverage)
• You become entitled to Medicare	36 months
• Your death	36 months
• Divorce or legal separation	36 months
• Dependent child loses eligibility	36 months

The COBRA periods shown above include any periods that the person was covered under any other continuation coverage.

The COBRA coverage will end sooner than stated in the previous chart if:

- this Plan terminates; or
- the person fails to pay the contribution on time; or
- the person becomes entitled to Medicare; or
- for a person who was Totally Disabled, he or she becomes ineligible for disability benefits under the Social Security Act. This will be the case only if the person is determined to be ineligible after he or she has been continuously covered under COBRA for at least 18 months, or
- the person becomes covered under another group plan.

If you or your Dependent has a pre-existing condition that will not be covered under the other group plan, then you will be able to continue under this provision until the earlier of:

- the end of the period shown in the previous chart; or
- the date on which the pre-existing condition becomes covered under the new group health plan.

When a qualifying event occurs, your Employer must give you the necessary COBRA election form within the time period specified by law You must complete and return this form to your Employer within 60 days of the later of.

- The date you or your Dependent would lose coverage; or
- The date you or your Dependent receives the COBRA election forms.

If you or your Dependent receives a Social Security disability determination, you must notify the Employer within 60 days of the determination and before the end of the initial 18 month COBRA coverage period in order to extend COBRA coverage to 29 months.

If you have questions about continuing benefits under COBRA, see your Employer.

■ Extended Benefits

If you or a Dependent is Totally Disabled on the date you become ineligible for continuation coverage or coverage under COBRA, you may still be eligible for certain benefits. These benefits are called "extended benefits." These benefits are payable.

- During the course of that Total Disability
- For the disabling condition only.
- Under the same benefit provisions as if coverage had not ended.
- For the period shown in the following extended benefits chart.
- Upon termination of your coverage under this Plan.

You do not have to pay for extended benefits.

Extended Benefits	
Coverage	**Length of Time Extended Benefits Are Available**
• Medical Benefits	90 days
• Dental Benefits	No extended benefits are available.
• Vision Benefits	No extended benefits are available.

Extended Benefits *(Continued)*	
• Prescription Drugs	No extended benefits are available under the Prescription Drug benefit. However, benefits for prescription drugs will be payable under the medical Plan for 90 days

Can I Convert My Coverage to Another Plan?

After continuation coverage, you also can receive coverage by converting to another plan.

■ Conversion of Medical Benefits

You must apply for medical conversion coverage within 31 days after your coverage ends.

Conversion coverage does not provide the same benefits as this Plan. If you are interested in converting your coverage, ask your Employer for details.

If you reside in Oregon:

- You will NOT be eligible to convert your coverage to conversion coverage. However, if your coverage under this Plan terminates, you may be eligible for health coverage through the Oregon Medical Insurance Pool (OMIP).
- You may apply for coverage through the OMIP ***only after you have applied for a private, individual health insurance policy and been declined*** or were offered a private, individual policy that excluded coverage for a pre-existing condition). You must:
  - Show a declination letter to the OMIP when you apply for OMIP coverage; and
  - Have been an Oregon resident for at least 6 months before applying to the OMIP; and
  - Not be eligible for Medicare or Medicaid.

  If you are accepted into the OMIP, there is a 6-month waiting period before coverage for care or treatment, including medications, for a pre-existing condition will begin. Certain factors may allow you to waive this 6-month waiting period:
  - You were previously covered by a group or individual health plan (prior plan) for which you did not have to fill out a health statement, including COBRA coverage; and
  - No more than 63 days have elapsed since coverage under the prior plan terminated; and

- You were covered under the prior plan for at least 6 months.

These factors will only allow you to waive the 6-month pre-existing condition waiting period. To be accepted into the OMIP, you must have applied for a private, individual health policy and been denied coverage.

For additional information, contact an insurance agent, broker or the Oregon Medical Insurance Pool Administrator at 1-800-848-7280 or, in the Portland area, at 225-6620.

Conversion coverage is not available to anyone who is entitled to Medicare Benefits.

You or your Dependents who elect coverage under COBRA may be able to convert the group coverage when the maximum time period allowed under COBRA runs out. However, you or your Dependents may be able to convert sooner if this Plan terminates, and is not replaced by similar group health coverage within 30 days.

You or your Dependents who are eligible for coverage under COBRA but do not elect it are not eligible to convert the group coverage.

Employee Conversion of Medical Benefits

If your coverage ends for any reason except not making a required payment, you may be able to convert your group coverage to other coverage. You can apply for conversion coverage if:

- You had been covered under this Plan (or any group health plan providing similar benefits which this Plan replaced) for at least 90 days just prior to the date your coverage ended, and
- This Plan is still in force; or
- This Plan terminates, and is not replaced by similar group health coverage within 30 days.

Spouse Conversion of Medical Benefits

Your spouse may convert his or her coverage if.

- You die; or
- Your marriage is annulled; or
- Your marriage ends in a divorce.

Dependent Child Conversion of Medical Benefits

Your Dependent children may convert their coverage if:

- You die and have no surviving spouse; or

- Their coverage ends only because they no longer meet the definition of "Dependent."

What Happens to My Coverage If I'm a Military Reservist and I'm Called to Active Duty?

This provision applies to you if you are a military reservist who is called to active duty for a period of more than 30 days.

■ If You Return to Work

If you:

- are honorably discharged; and
- return to work with your Employer within the time period specified in the Uniformed Services Employment & Re-employment Rights Act;

then on the date you return to work, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents on that date.

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How Does Great-West POS Work?

Your medical benefits are provided under a managed care program called Great-West POS. The Great-West POS plan is effective JANUARY 1, 1998.

When you enroll in the Plan, you and each of your covered family members selects a Primary Care Physician (PCP) in the Great-West POS network. Your PCP becomes the manager of your health care. He or she will coordinate your health care and refer you to participating specialists and Hospitals when necessary

Great-West POS offers two levels of benefits: approved (high) and non-approved (low).

In order for covered services to be paid at the high level, care must either be provided by the PCP or approved by the PCP ***and*** provided by a network provider. When these conditions are ***not*** met, benefits will be paid at the non-approved level.

Your PCP will help ensure that you receive medically appropriate care, and by involving your PCP in all health care decisions, you receive the continuity of care that only a personal Physician can provide.

You may call the Member Services number listed on your ID card for help in selecting a PCP and with other customer service issues.

■ How Do I Choose a Primary Care Physician?

PCPs may be either general or family practitioners, internists or pediatricians. In addition, participating gynecologists and obstetricians practicing in the states of California or Oregon who have agreed to provide the majority of primary health care services may be PCPs. Each family member may choose a different PCP.

When selecting a PCP, call the Member Services telephone number listed on your ID card. You may also call this number for help with customer service issues.

Complete the Enrollment Application indicating a choice of Primary Care Physician (PCP) for each covered family member. Keep the last copy of the Enrollment Application so that you have a record of your family's chosen PCPs.

■ What Should I Do When I Need Health Care?

- As a rule, you should always call your PCP before seeking any medical treatment. Routine medical problems can be handled in your PCP's office. However, if Medically Necessary, your PCP will refer you to the appropriate health care provider

Annual gynecological exams are an exception. Once each year, women may use a network obstetrician-gynecologist (OB-GYN) for one routine exam *without* getting PCP approval. This annual exam may include a pelvic exam, a Pap smear, and (for women age 35 and over), a mammogram.

Mental health services are also an exception. These services require approval by the Managed Mental Health Program (MMHP) rather than by your PCP.

- Present your ID card each time you or a Dependent receives care. Your PCP and other Great-West POS network providers will use the information on this card to file claims for you. Until you receive your ID card, carry a copy of your Enrollment Application with you. Some Doctors will accept it as if it were your actual ID card.
- You may need to file a claim if you receive non-approved care. Claim forms are available from your Employer.

■ What Is An Authorized Referral?

An authorized referral is more than your PCP's verbal advice. It is part of a process that helps ensure that you receive appropriate care and that benefits are paid correctly.

When specialist care is required:

- The provider must be a member of the Great-West POS network; and
- Your PCP or his or her medical group must notify Member Services that care has been approved;

for services to be paid at the high level.

■ When Do I Need An Authorized Referral?

To receive the highest level of benefits under the Plan, you must receive an authorized referral for all services outside your PCP's office and care must be provided by a network provider.

■ What If I Need Further Specialist Care?

Depending on your condition, your PCP may approve one office visit or a series of visits to a specialist or other provider In some cases, your PCP may approve additional treatment without requiring another office visit, but please remind your PCP to inform Member Services of this.

What Happens If I Don't Receive Approval?

With Great-West POS, you always have a choice. You are free to receive care without your PCP's approval; however, benefits will be paid at the lower, non-approved level of benefits. In all likelihood, you'll be required to pay at the time services are provided or will receive a bill, which means that you must file a claim.

What If I Need Inpatient Hospital Care?

In addition to receiving approval from your PCP, you must use a network provider to receive the higher level of benefits.

Contact Member Services before you receive care for information on participating Hospitals.

What If I Need Mental Health Services?

For assistance with mental health problems, call the toll-free Member Services number printed on your ID card.

The Managed Mental Health Program (MMHP) is a counseling and referral service staffed with privately practicing mental health professionals. You'll talk with specially trained counselors who will help you determine the level of care that's right for your unique situation. You will receive authorization for services or denial of approval at the time of request.

When you see providers who belong to the MMHP network, just present your ID card. You won't have to file claim forms *or get approval from your PCP.* For treatment of mental/nervous conditions or substance abuse, services will be considered "PCP Approved" *only* if they are approved by the MMHP. To contact the MMHP, call Member Services.

What Should I Do If I'm Out of Town and Need Treatment?

If you need non-emergency care, call your PCP first. He or she will assess your condition and may be able to give you medical advice over the phone.

If you need emergency care, you should go to the nearest available medical facility. Contact your PCP within 2 working days. If this is not practical, your PCP must be contacted as soon as reasonably possible.

The term "emergency" means the sudden, unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's life in serious jeopardy;
- Serious injury or impairment of bodily functions; or

- Serious or permanent dysfunction of any bodily organ or part.

What Should I Do if I Need Urgent Medical Care?

Whether you are inside or outside the service area and need urgent medical care, you should call your PCP before seeking treatment. This requirement will be waived only if it is shown that it was not reasonably possible to contact your PCP, in which case you must contact him or her within 2 working days or as soon as reasonably possible.

The term "urgent medical care" means care for an injury or illness which requires medical attention within a short period of time in order to prevent serious deterioration of a patient's health.

What If I'm Unable To Reach My PCP?

If your PCP is on vacation, ill or otherwise unavailable, call Member Services. The Member Services representative will refer you to another network Physician who will act as your PCP until your PCP is available.

Can I Change My PCP?

You and your Dependents may select a new PCP at any time. Just call the toll-free Member Services number printed on your card. The Member Services representative can help you find a PCP who meets your needs and will tell you the date the change will go into effect.

Why You Should Always Carry Your I.D. Card With You.

It's important that you carry your I.D. Card at all times. This card shows health care providers that you are covered under Great-West POS and provides them with information about Plan requirements. Your card also lists the amount of your office visit co-pay and the toll-free number for Member Services.

Contact Member Services With Questions.

Don't hesitate to call. Member Services is there to help. Representatives will note your suggestions concerning policies or services of the Great-West POS plan, and will answer all types of questions - from how your Plan works and which services are covered, to who is eligible for coverage. They can even help you find a conveniently located Hospital or Physician.

Calendar Year Deductible

A calendar year deductible is the amount of covered medical expenses that you or a Dependent must incur before the Plan begins to pay benefits.

Benefits that are payable at 100% or subject to a co-pay or per-visit deductible are not subject to this deductible and cannot be used to satisfy it.

Benefits that are used to satisfy the calendar year deductible for non-approved services may not be used to satisfy the deductible for PCP approved services Benefits that are used to satisfy the calendar year deductible for PCP approved services may not be used to satisfy the deductible for non-approved services.

Approved

Your Plan's calendar year deductible for PCP approved services is $200 00.

To limit your family's out-of-pocket expenses, the maximum deductible for you and all your covered Dependents is $600.00. No more than $200.00 per individual will be applied to the family deductible.

Not Approved

Your Plan's calendar year deductible for services not approved by your PCP is $500 00.

To limit your family's out-of-pocket expenses, the maximum deductible for you and all your covered Dependents is $1,500.00. No more than $500.00 per individual will be applied to the family deductible.

Calendar Year Deductible Carryover

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines. These guidelines help control medical plan costs by setting a limit on the amount covered for each medical procedure.

- Hospitals and Physicians under contract with Great-West agree to a set fee schedule for people enrolled in Great-West POS. When you see a Great-West POS participating provider, or any other provider who is under contract with Great-West, the allowable covered expense will be the amount specified in the fee schedule. The provider cannot bill you for any expenses in excess of the scheduled amount.
- When you see a provider who is not under contract with Great-West, the allowable covered expense will be determined by usual and customary charge guidelines. The usual and customary charge for each service or supply you receive will be the lesser of these two amounts:
  - The fee usually charged by your Doctor for these services and supplies.
  - The fee usually charged by other Doctors in the same geographical area for these services and supplies

You are responsible for any amounts that are more than usual and customary charges.

Maternity Coverage

Your maternity coverage includes prenatal care, childbirth, and post-natal care

This Plan provides coverage for:

- a 48-hour Hospital stay for you and your baby following a normal vaginal delivery.
- a 96-hour Hospital stay for you and your baby following a cesarean section.

A Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for an early discharge is made by the attending Physician in consultation with the mother.

Summary of Medical Benefits

The following chart is a brief summary of the medical benefits offered by your Plan. Please read the rest of this section for details about covered expenses, limitations and exclusions under the Plan.

Summary of Medical Benefits	
CALENDAR YEAR DEDUCTIBLE	
The calendar year deductible applies to all covered expenses except those payable at 100% and expenses subject to a co-pay or per-visit deductible.	
Individual	
- Approved	$200.00
- Not Approved	$500.00
Family	
- Approved	$600.00
- Not Approved	$1,500.00
PERCENTAGE PAYABLE	
Inpatient and Outpatient Hospital Care	
• Approved	90%
• Not Approved	50% after $250.00 per occurrence deductible
Physician charges for Surgery and Hospital Care	
• Approved	100%
• Not Approved	50%

Summary of Medical Benefits *(Continued)*	
Office Visits	
• Approved	100% after $10 00 co-pay
• Not Approved	50%
Gynecological Services	
• Annual basic services by an OB/GYN who is a participating provider.	100% after $10.00 co-pay
• Other gynecological services	
- Approved	100% after $10.00 co-pay
- Not Approved	50%
Preventive Care	
• Approved	100% after $10.00 co-pay
• Not Approved	50%
Well Newborn Care	
• Office Visits	
- Approved	100% after $10.00 co-pay
- Not Approved	50%
• Inpatient and Outpatient Hospital Care	
- Approved	90%
- Not Approved	50% after $250.00 per occurrence deductible
Emergency Room Treatment	
•Approved	
- If you are admitted to the Hospital as an inpatient	90%, no calendar year deductible for emergency room charges However, the calendar year deductible applies to charges for the inpatient confinement.
- If you are not admitted to the Hospital as an inpatient	90% after $45.00 per visit deductible, no calendar year deductible
• Not Approved	50%
TMJ Treatment	

Summary of Medical Benefits *(Continued)*	
• Office Visits	
- Approved	100% after $10.00 co-pay
- Not Approved	50%
• Inpatient and Outpatient Hospital Care	
- Approved	90%
- Not Approved	50% after $250.00 per occurrence deductible
Mental/Nervous and Substance Abuse Treatment	
• Inpatient Treatment	
- Approved	90%
- Not Approved	50% after $250.00 per occurrence deductible
• Outpatient Treatment	
- Approved	100% after $45.00 co-pay
- Not Approved	50%
Spinal Adjustment/Treatment	
• Office Visits	
- Approved	100% after $10.00 co-pay
- Not Approved	50%
Hospice Care	100%
Other Covered Expenses	
• Approved	100%
• Not Approved	50%
BREAKPOINT	
Individual	
- Approved	$10,000.00
- Not Approved	$20,000.00
Family	
- Approved	$30,000.00
- Not Approved	$60,000.00
BENEFIT MAXIMUMS	
• Lifetime TMJ Treatment	$2,000.00
• Calendar year inpatient mental/nervous and substance abuse	30 days

Summary of Medical Benefits *(Continued)*	
• Lifetime inpatient mental/nervous and substance abuse	60 days
• Calendar year outpatient mental/nervous and substance abuse	20 visits
• Lifetime outpatient occupational, speech and hearing therapy	$2,000.00
• Calendar year spinal adjustment and treatment	$500 00
• Maximum Benefit for ALL covered expenses (per covered person)	$2,000,000 00

What Medical Expenses Are Covered?

■ Care Received in a Hospital

Covered expenses for care received in a Hospital include charges for room and board as well as other inpatient and outpatient services and supplies

- For room and board, the covered expense for each day of confinement is limited to the Hospital's usual charge for semi-private care.
- For confinement in an intensive care unit, the covered expense for each day is limited to the Hospital's usual charge for confinement in an intensive care unit.

Benefits for emergency room treatment are described later in this booklet. (See "Treatment in An Emergency Room".)

Approved

If services are approved by your PCP and provided in a participating Hospital, benefits are payable at 90% after the calendar year deductible.

Not Approved

Hospital services are considered "non-approved" unless they are approved by your PCP and, for inpatient care, provided in a participating Hospital.

If services are non-approved, an additional $250.00 deductible will be applied to your claim. This is called a non-PCP per-occurrence deductible. It will be applied to facility charges for each inpatient confinement or outpatient surgery.

After satisfaction of the calendar year deductible and the per-occurrence deductible, non-approved Hospital charges are payable at 50%.

Skilled Nursing Facility Expenses

If you no longer need the level of care provided in the Hospital but are not yet well enough to go home, you may be admitted to a skilled nursing facility.

- The total covered expense for each day in a skilled nursing facility is limited to the usual charge of the facility for semi-private care. This daily covered amount includes room and board and all other services; and
- This covered daily amount will not be more than 1.5 times the amount covered for room and board in the last Hospital in which the patient was confined.

The Plan will pay for up to 90 days of care in a skilled nursing facility each calendar year.

To receive skilled nursing facility benefits, you must be sure that the skilled nursing facility you choose is licensed by the state as a skilled nursing facility. In addition, confinement in a skilled nursing facility must:

- Start within seven days after the end of a Hospital confinement. The Hospital confinement must have lasted at least three days.
- Be necessary for treatment of the same condition that caused the Hospital confinement. This must be certified by the patient's Doctor
- Not be chiefly for the kind of care that helps a person perform the activities of daily living.

Approved

If services are approved by your PCP, benefits are payable at 90% after the calendar year deductible.

Not Approved

After satisfaction of the calendar year deductible, charges not approved by your PCP are payable at 50%.

■ Physician Charges For Surgery Or Hospital Care

If you are admitted to a Hospital, you may incur Physician or surgeon charges that are separate from your Hospital bill. These fees are covered under this category of benefits.

Once again, the provider you choose will impact the level of benefits you receive.

Approved

If services are approved by your PCP, benefits are payable at 100%.

Not Approved

For non-approved services, benefits are payable at 50% after the calendar year deductible.

■ Office Visits

Covered expenses for office visits include expenses for most services and supplies (x-rays, lab tests, drugs) provided in the Doctor's office.

Expenses for office visits are payable as follows.

Approved

For each office visit, you only pay a $10.00 co-pay. The balance of the office visit is payable at 100%. You do *not* have to satisfy the calendar year deductible before these benefits are payable.

Office visits include expenses for the following services and supplies:

- drugs provided in the Doctor's office;
- surgeries performed in the Doctor's office;
- x-rays and lab tests provided in the Doctor's office or ordered during an office visit but performed at an independent facility, except for the following procedures.
  * mammograms not performed as a result of a PCP's referral or as part of "Annual Basic Services";
  * second and subsequent mammograms performed in any one calendar year;
  * Computerized Tomography (any area), Magnetic Resonance Imaging (any site or area), or similar procedure such as CAT or PET scans;
  * any procedure or x-ray done in conjunction with the introduction or ingestion of a contrast medium or dye such as Myelography and Discography;
  * any diagnostic ultrasound procedure (any area);
  * radiation oncology procedures including all types of radiation therapy;
  * nuclear medicine procedures and imaging (any area);
  * tissue typing (all types);
  * postmortem examinations;
  * cytogenetic studies; and
  * surgical pathology.

Not Approved

Benefits are payable at 50% after the calendar year deductible

■ Gynecological Services

Annual Basic Services

You may self-refer to a participating OB/GYN for basic services once per year, without PCP approval

Basic services include an annual pelvic exam, Pap smear and, for women age 35 and over, mammogram. You only pay a $10.00 co-pay. The balance of the office visit is payable at 100%. You do ***not*** have to satisfy the calendar year deductible before these benefits are payable.

If results indicate that follow-up care is required:

- you must obtain approval from your PCP for continued treatment; and
- services must be provided by a member of the POS network,

in order to be paid at the high level.

Other Gynecological Services

- Approved

  For each office visit, you only pay a $10.00 co-pay. The balance of the office visit is payable at 100%. You do ***not*** have to satisfy the calendar year deductible before these benefits are payable.

- Not Approved

  Benefits are payable at 50% after the calendar year deductible.

■ Preventive Care

This benefit is designed to prevent more serious and costly illnesses by providing coverage for routine health care. This Plan will pay for the preventive care services listed below.

For a person who is at least eight days of age, preventive care includes:

- A physical examination of the heart, lungs and abdomen by a Doctor;
- X-ray and laboratory services required as part of the exam; and
- Necessary immunizations and booster shots.

For a female of any age, preventive care includes routine Pap smears, mammograms and pelvic exams.

Approved

Each time you see a Physician in his or her office for preventive care, you only pay a $10.00 co-pay. The balance of the office visit is payable at 100%. You do ***not*** have to satisfy the calendar year deductible before these benefits are payable.

Not Approved

Benefits are payable at 50% after the calendar year deductible

■ Well Newborn Care

Of course, babies who are born with medical problems are covered as any other Dependent under this Plan. But even healthy babies may receive medical care, so this Plan also includes benefits to give your healthy baby a good start in life. Covered expenses for well newborn care include Hospital and Physician charges for infant care through the first seven days of life.

To receive this benefit you must have Dependent coverage.

Approved

For each well newborn office visit to a Physician, you only pay a $10.00 co-pay The balance of the office visit is payable at 100%. You do *not* have to satisfy the calendar year deductible before these benefits are payable.

For inpatient Hospital care and inpatient and outpatient surgery, benefits are payable at 90% after the calendar year deductible.

Not Approved

After satisfaction of the calendar year deductible and the per occurrence deductible, non-approved treatment is payable at 50% The per occurrence deductible does not apply to well newborn office visits.

■ Treatment in an Emergency Room

Charges for emergency room treatment are covered under a separate benefit that includes both facility and Physician fees.

Approved

- Facility charges are covered at 90% after the $45.00 emergency room per visit deductible. If you are admitted to the Hospital as an inpatient, the emergency room per visit deductible will be waived.
- Physician fees are covered at 90%.

The calendar year deductible does not apply to emergency room visits.

Not Approved

Facility charges and Physician fees are covered at 50% after the calendar year deductible.

■ Treatment of TMJ and Related Disorders

This Plan covers treatment of craniofacial muscle disorders and temporomandibular disorders.

Up to $2,000.00 is payable during the entire time the person is covered under this medical Plan.

This treatment includes, but is not limited to:

- Hospital care, surgery and manipulation under anesthesia;
- Exams and diagnostic x-rays, muscle injections, nerve block injections, jaw tracking, and drug therapy; and
- Grinding the surface of the teeth, splints and appliances, orthodontic treatment (such as braces or wires), and change of vertical dimension, including crowns.

No amount will be paid for electromyography, sonography, thermography, study models, dietary and related biochemical analysis, or dental kinesiology.

Approved

For each office visit for TMJ treatment, you only pay a $10.00 co-pay. The balance of the office visit is payable at 100%. You do *not* have to satisfy the calendar year deductible before these benefits are payable.

For inpatient Hospital care and inpatient and outpatient surgery, benefits are payable at 90% after the calendar year deductible.

Not Approved

After satisfaction of the calendar year deductible, non-approved treatment is payable at 50%. An additional $250.00 per occurrence deductible will be applied to each inpatient confinement or outpatient surgery.

■ Treatment of Mental/Nervous Conditions and Substance Abuse

The mental/nervous and substance abuse benefit provides coverage for mental health services, including treatment for alcoholism, drug addiction and other substance abuse. This benefit includes coverage for both inpatient and outpatient treatment.

Inpatient Treatment

Covered expenses for inpatient treatment are payable at.

- 90% after the calendar year deductible if approved by the Managed Mental Health Program (MMHP). To contact the MMHP, call the toll-free number printed on the front of your I.D. card.
- 50% after the calendar year deductible if not approved by the MMHP. An additional $250.00 per occurrence deductible will be applied to Hospital charges for each inpatient confinement.

The Plan will pay up to:

- 30 days of inpatient treatment in any calendar year; and
- 60 days of inpatient treatment during the entire time the person is covered under this medical Plan.

Outpatient Treatment

Covered expenses for outpatient treatment by a Doctor are payable at:

- 100% after the $45.00 co-pay if provided by or approved by the MMHP. The calendar year deductible does not apply.
- 50% after the calendar year deductible if not approved by the MMHP.

The Plan will pay up to 20 visits in any calendar year

■ Spinal Adjustment and Treatment

The Plan will pay for covered expenses for services related to spinal adjustment.

Up to $500 00 is payable in any calendar year.

No benefits are payable for massage.

Approved

For each office visit for spinal adjustment and treatment, you only pay a $10.00 co-pay. The balance of the office visit is payable at 100% You do ***not*** have to satisfy the calendar year deductible before these benefits are payable.

Not Approved

After satisfaction of the calendar year deductible, non-approved treatment is payable at 50%

■ Other Covered Medical Expenses

Other covered medical expenses include:

- Outpatient Occupational, Speech and Hearing Therapy.
- Home Health Care
- Other Medical Services and Supplies

Approved

Benefits for PCP approved services are payable at 100%.

Not Approved

After satisfaction of the calendar year deductible, treatment not approved by your PCP is payable at 50%.

Outpatient Occupational, Speech and Hearing Therapy

This category of expenses includes outpatient services of licensed occupational, speech and hearing therapists.

Up to $2,000 00 is payable during the entire time the person is covered under this medical Plan.

Therapy provided during an inpatient Hospital stay is payable on the same basis as other inpatient Hospital care.

Home Health Care

There are many instances in which a patient might prefer home health care to an inpatient Hospital stay. Such patients typically need a certain level of medical care, but not the full-time supervision of a Hospital staff.

When prescribed as an alternative or as a follow-up to inpatient Hospital care, medical services provided in the home by a licensed home health care agency are covered as a cost-effective service.

The Plan will pay for one home health care visit per day, up to 100 home health care visits per calendar year.

Other Medical Services and Supplies

Medical services and supplies include:

- Nursing services.
- Medical equipment
- Physical therapy.
- Ambulance services.
- Services and supplies required for the treatment of diabetes and diabetes self-management education programs.
- When required as a result of a mastectomy, reconstructive surgery (payable on the same basis as any other surgery) and any prosthetic device.

■ Hospice Care

Hospice care can provide the physical, psychological, spiritual or social support needed to help terminally ill patients cope with their Illnesses. Hospice care includes services provided by a hospice care program in the patient's home, a Hospital or a hospice. These services are covered as long as they are prescribed by a Doctor, and the covered person's life expectancy is six months or less.

Hospice care is payable at 100% and is not subject to the calendar year deductible.

■ Alternate Care and Treatment

Hospital confinement is not always the best environment for treating an Illness. For a patient who needs significant long-term medical supervision, Great-West or the Managed Mental Health Program (MMHP) may recommend alternative care and treatment.

The Case Management (CM) program helps patients manage their health care. The goal of the CM program is to develop alternative treatment plans that will help patients obtain the type of care they need ***outside*** of a Hospital setting. A patient who chooses to participate in this program is assigned a case manager, who will help coordinate the patient's care.

As a part of the pre-treatment authorization or CM program, an alternate treatment plan or facility may be recommended that.

- Is not included in this medical Plan; or
- Is included in this medical Plan, but on a basis that differs from the care and treatment being recommended by the CM program.

If you and your Doctor decide that the recommended alternative treatment plan is right for you, these expenses are payable on the same basis as the care and treatment for which they are substituted.

Great-West or the MMHP may authorize coverage for such alternate forms of care and treatment without obtaining prior consent from your Employer.

What's Not Covered?

■ Pre-Existing Conditions Limitation

*This section will **not** apply to a child placed with you for adoption*

A pre-existing condition is an Illness or any related condition for which you or your Dependent received services, supplies or medication during the 3 months before the enrollment date for you or your Dependent under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received after:

- You or your Dependent has not received services or medication for this condition for 3 months; or
- 12 months after the enrollment date for you or your Dependent.

If you are a late applicant as described in the section, "What If I Don't Apply For Coverage When I'm First Eligible?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 18 months after your enrollment date.

"Enrollment date" means:

- for an Employee who applies for coverage for himself or herself during the 31-day period after first becoming eligible to do so (the Employee's initial application period), the first day of the Employee's Service with the Employer.
- for an eligible Dependent for whom application for coverage is made during the 31-day period after the Employee's initial application period, the first day of the Employee's Service with the Employer.
- for a late applicant or special enrollee (as described in the section, "What If I Don't Apply For Coverage When I'm First Eligible?"), or for any newly acquired Dependent, the date the person becomes covered under this Plan.

Portability of Coverage

A person (you or your Dependent) will receive credit toward satisfaction of the Pre-Existing Condition Limitation described in this section for the time he was covered under another health plan, but only if:

- Your Service begins after the effective date of this Plan; and
- The person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 62-day period just before his or her enrollment date under this Plan.

  Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 62-day period.

If the person was covered for a period of time under Creditable Coverage that is:

- greater than or equal to the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- less than the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

  However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

"Creditable Coverage" is defined as coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived.

General Benefit Limitations

The following limitations apply to all medical treatment you receive.

Benefits are payable only if the medical expenses are for treatment that is:

- Medically Necessary; and
- Except for preventive care and well newborn care, required as a result of symptoms of Illness; and
- Recommended, performed or prescribed by a Doctor; and
- The least expensive, medically acceptable service or supply, as determined by Great-West; and
- Incurred while you or your Dependent is covered for these medical benefits. Treatment is considered to be incurred on the date the service is rendered or the supply is provided No benefits are payable for expenses incurred after termination of coverage except as provided in the Extended Benefits provision of this booklet. See "When Coverage Begins and Ends" (Eligibility).

No amount will be payable for:

- An accidental injury that occurs while working for pay or profit.
- A sickness for which the covered person is entitled to benefits under any Worker's Compensation or similar law, whether or not he or she has declined participation under the law. This limitation for sickness does not apply to proprietors, partners or executive corporate officers of the Employer.
- Services or supplies:
  - Provided by any government health plan; or
  - For which there would be no cost to the covered person if he or she did not have coverage.

  Benefits payable under this medical Plan will not be reduced or denied because the covered person is entitled to benefits under a state-sponsored medical assistance program, but those benefits will be paid to the state. Any amount the Plan pays:
  - Will be considered benefits paid under this medical Plan; and
  - Will constitute a full discharge of the Plan's liability to the extent of the payment.
- Expenses that are incurred:

- For treatment provided by your spouse, children, brothers, sisters, parents or grandparents; or
- For treatment provided by your spouse's children, brothers, sisters, parents or grandparents

- Cosmetic surgery and all expenses related to the surgery, unless the operation is performed or the treatment is rendered to correct:
  - Deformities that result from Illness; or
  - Congenital defects that interfere with bodily but not psychological function; or
  - Any congenital defect of a newborn child.
- Any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT).
- Infertility testing.
- Tubal ligations.
- Vasectomies.
- Experimental or Investigational treatment or procedures.
- Custodial care. "Custodial care" means the kind of care that helps you perform the activities of daily living, such as, but not limited to.
  - Help in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet.
  - Preparation of special diets.
  - Housekeeping.
  - Supervision of medication which:
    * Does not need the continuing attention of trained medical or paramedical personnel; and
    * Can usually be administered by yourself, a member of your family, or any other person who has not had formal medical training.
- Radial keratotomy.
- The reversal of any sterilization procedure.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Hearing aids or the fitting of hearing aids

- Dental services other than treatment of accidental injuries to natural teeth within six months after the Accident. Chewing Injuries are not considered accidental injuries.
- Services and supplies received for an Illness that is a result of war, declared or undeclared.
- Non-prescription drugs or medicines, or drugs or medicines that are not approved under the United States Food and Drug Act or its successor(s).
- Anti-obesity drugs and formulas.
- Special nursing services if those same services are provided by the regular nursing staff of any Hospital in which the patient is confined.
- Charges by a Doctor for any phone call or interview during which the patient is not examined.
- Smoking cessation programs.
- Oral contraceptives.
- Drugs, medicines or insulin which are received as an outpatient (See Great-West POS Prescription Drug Benefits (POS Drugs).)

Do I Have Protection Against High Out-of-Pocket Expenses?

To help protect you and your family against high health care expenses, your Employer has set breakpoints for your Plan. A breakpoint is the level of covered expenses at which you will receive 100% benefits

■ Calendar Year Breakpoint for Approved Services

Your Plan's calendar year breakpoint is $10,000.00. This means that if covered expenses for you or one of your Dependents reach $10,000.00 in any one calendar year, all other covered expenses for that person during the rest of that calendar year will be payable at 100%.

To limit your family's out-of-pocket expenses, the maximum breakpoint for you and all your covered Dependents is $30,000.00. No more than $10,000.00 per individual will be applied to the family breakpoint.

■ Calendar Year Breakpoint for Non-Approved Services

Your Plan's calendar year breakpoint is $20,000.00. This means that if covered expenses for you or one of your Dependents reach $20,000.00 in any one calendar year, all other covered expenses for that person during the rest of that calendar year will be payable at 100%.

To limit your family's out-of-pocket expenses, the maximum breakpoint for you and all your covered Dependents is $60,000.00 No more than $20,000.00 per individual will be applied to the family breakpoint.

Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse will *not* be payable at 100% even if you have reached your breakpoint.

■ Expenses That Do Not Count Toward the Breakpoint

The following medical expenses will not be used to satisfy your individual or family breakpoint.

- Covered expenses used to satisfy any deductible or co-pay amounts.
- Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse.
- Covered expenses that are payable at 100%.
- Expenses for services and supplies not covered under this Plan.

Is There a Limit on the Amount of Medical Benefits I Can Receive?

The provision entitled "What Medical Expenses Are Covered?" describes the calendar year and lifetime benefit maximums that apply to specific types of covered expenses. This medical Plan also includes an overall maximum benefit that applies to all covered expenses.

The maximum amount payable for any one person is $2,000,000.00 during the entire time he or she is covered under this medical Plan.

How Are My Benefits Affected When My Employer Transfers Medical Claims Processing to Great-West?

During the calendar year that your Employer transfers medical claims processing to Great-West, your claims will be paid on the following basis:

■ Deductible Credits

Any amount you've already paid toward the medical deductible under the prior medical plan will be applied to this Plan's deductible for Approved expenses.

■ Breakpoint Credits

Any amount of covered expenses you've already used to satisfy any breakpoint under the prior medical plan will be applied to this Plan's breakpoint for Approved expenses.

Special Benefits for Pre-Existing Conditions

This transfer provision includes special benefits for you if you or your Dependent had a pre-existing condition at the time your coverage was transferred to Great-West. If you or your Dependent:

- Would otherwise be ineligible for coverage under this Plan because of the pre-existing conditions limitation; and
- Is not eligible for benefits under your prior plan because of a contractual limitation or exclusion of benefits for expenses incurred after termination of that plan;

then you or your Dependent will be eligible for benefits that are the lesser of:

- The amount that would have been paid under the prior plan if it had stayed in force; and
- The amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

If coverage transfers to Great-West within 90 days from the time your coverage terminated under a prior carrier and coverage under a prior carrier was "Qualifying prior coverage", then.

- You or your Dependent will be eligible to receive credit toward the pre-existing conditions limitation referred to in this medical Plan, if you or your Dependent were covered under the prior plan for less than 3 months. The pre-existing conditions waiting period referred to in this provision will be reduced by the number of consecutive months you or your Dependent were covered under the prior plan.
- You or your Dependent will not be required to satisfy the pre-existing conditions limitation referred to in this medical Plan, if you were covered under the prior plan for longer than 3 months.

  The term "Qualifying prior coverage" will include.

  - A plan that is substantially similar to this Plan.
  - A self-funded plan, including a state or local government self-funded plan.
  - The Uniform Plan.
  - The Basic Health Plan.
  - The Washington State Health Insurance Pool.
  - Medicaid.

■ Effect of Transfer on Benefit Maximums

Any calendar year benefit maximum under this Plan will be reduced by the amount paid under the prior plan in the calendar year in which your Employer transfers claims processing to Great-West.

How Will Benefits Be Affected By Medicare?

If you are an active Employee and you or your Dependents become eligible for Medicare due to age or disability, you and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. Your benefits will not be reduced by any Medicare benefit you or your Dependents receive. Instead, this Plan will coordinate benefits with Medicare.

Unless you choose otherwise, your coverage under this medical Plan will be considered your primary coverage, and Medicare will be considered your secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.

If you choose Medicare as your primary coverage, you will lose all coverage under this medical Plan. See your Employer for details.

■ If You or a Covered Dependent Becomes Eligible for Medicare Due to End-Stage Renal Disease

For the first 30 months of treatment for End-Stage Renal Disease (ESRD), your coverage under this medical Plan will be the primary coverage. After that, Medicare will become the primary coverage.

Where To Find The Answers To Your Questions

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How Does Great-West PPO Work?

Your medical benefits are provided under a managed care program called Great-West PPO.

There are two important features of Great-West PPO:

- *A Nationwide Network of Hospitals and Physicians*
- *Medical Management*

How Does the Great-West PPO Network Work?

Great-West PPO uses a nationwide network of Hospitals and Physicians. This means that network providers are often available when you travel or if you have covered Dependents in other areas.

Great-West carefully screens all Hospitals and Physicians before inviting them to join the Great-West PPO network. As part of this screening process, network recruiters scrutinize staff credentials, medical equipment, patient records, and office policy and procedures.

Hospitals and Physicians who are part of the Great-West PPO network have agreed to a set fee schedule for people enrolled in the Great-West PPO plan. When combined with the higher in-network level of benefits you receive, these reduced fees can lower your out-of-pocket costs.

How Does Medical Management Work?

Medical Management is a telephone-based utilization review program, operated by Doctors and nurses, that helps you receive appropriate care for your condition and control your out-of-pocket costs. This program includes:

- Pre-treatment review of all Hospital stays and surgeries to help protect you from receiving outdated or unnecessary treatment.
- Discharge planning to ensure that Hospital stays are only as long as Medically Necessary and to identify alternatives to extended Hospital stays.
- Identification of patients who might benefit from Great-West's Case Management program.

Your Doctor will talk with the medical professionals at Medical Management to determine a treatment plan - ***before*** you receive treatment.

Medical Management will determine and authorize:

- The medical necessity of the treatment;
- The appropriate location for the treatment to be provided; and
- If you need to be admitted to a Hospital, the appropriate length of stay

In addition, Medical Management will inform your Doctor of any cost-saving features that your Plan may have

■ Are Benefits Guaranteed If I Get Approval from Medical Management?

Of course, you must be eligible to receive benefits under this Plan to receive coverage for any treatment. Obtaining pre-treatment authorization from Medical Management does *not* guarantee eligibility or coverage. To verify that you or a family member is eligible for benefits and to confirm coverage, you should call your Employer.

■ How Do I Use Medical Management?

When your Doctor recommends a Hospital stay or surgery outside his or her office, follow these steps:

- Seven to ten days before you have surgery or are admitted to a Hospital, ask your Doctor to call the toll-free Member Services number printed on your ID card.
- Your Doctor will discuss your condition and the proposed treatment plan with the Medical Management staff nurse. In most cases, treatment is authorized during the call.
- When pre-authorization is not possible due to an Accident or the sudden onset of an Illness, your Doctor must call Medical Management within 48 hours after treatment begins, or on the next business day.

Both you and your Doctor will receive verification that your treatment has been authorized. If you wish, you also may call the toll-free number printed on your ID card for verification.

■ What Happens If I Don't Use Medical Management?

All network Physicians have agreed to contact Medical Management for pre-treatment review as part of their contracts.

However, if you use a non-network Physician, it is your responsibility to make sure that Medical Management is contacted when necessary. If your Physician does not obtain pre-treatment authorization from Medical Management, or you do not follow the Medical Management-recommended treatment plan, a $250.00 non-compliance penalty will be applied to your claim. This non-compliance penalty cannot be used to satisfy the calendar year deductible or the breakpoint.

What Should I Do When I Need Health Care?

When you need care, you may choose any Physician you wish. You are not required to see the same Doctor each time. However, you'll usually receive a higher level of benefits when you choose network Physicians.

- Your Great-West PPO provider directory lists the network Hospitals and Physicians in your area. The listing may change from time to time, so it's a good idea to check with Member Services to confirm that a provider is still a network member. For a listing of providers in other cities, contact your Employer.
- Every time you go to a network Physician, show your Great-West PPO ID card. It identifies that your Employer has chosen Great-West PPO and provides important information used in billing for services.
- Network Physicians will submit your claims for you. They'll also take care of calling Medical Management whenever necessary. However, if you use non-network providers, you may have to file your own claims, and you will be responsible for making sure pre-treatment authorization requirements are met.
- To receive benefits at the network level, ask the Doctor to refer you to a network specialist or Hospital if you need additional treatment or testing.

What Should I Do in Case of an Emergency?

In case of a life-threatening emergency, go immediately to the nearest Hospital for treatment. In most cases, emergency room treatment is covered at 80%, regardless of the facility you choose. If you need to be hospitalized after receiving treatment in the emergency room, ask to be admitted to a Great-West PPO network Hospital. This way, your Hospital treatment will be covered at the higher benefit level.

Remember, if you are admitted to the Hospital or require surgery, your Doctor must call Medical Management within 48 hours after treatment begins, or on the next regular business day. If treatment is not authorized, the $250.00 non-compliance penalty will be applied to your claim.

Will Non-Network Services Ever Be Payable At The Network Level?

The following services will be payable at the network level even if they are not performed by a Great-West PPO provider

- X-rays or laboratory tests ordered by a Great-West PPO Physician when provided outside of a Hospital;
- X-rays or laboratory tests in a Great-West PPO Hospital; and

- Services of an anesthesiologist or assistant surgeon when the surgery is performed by a Great-West PPO Physician in a Great-West PPO Hospital.

What If a Great-West PPO Provider Is Not Accessible to Me?

In the following situations, non-network services will be payable at 80%.

- If treatment is a result of an emergency; or
- If treatment is received outside the designated geographic area of Great-West PPO as defined in the current Great-West PPO directory.

The term "emergency" means:

- An accidental injury that requires immediate treatment; or
- Life threatening Illness that requires immediate treatment. The Doctor who attends the covered person must certify that the Illness was life threatening.

If the covered person was first confined in a Great-West PPO Hospital and later transfers to a non-Great-West PPO Hospital, benefits are payable at 60% after the calendar year deductible.

How Can I Help Control My Health Care Costs?

Health care is like any other product or service you buy - you want to get the best value for every dollar. Great-West PPO is designed to help you control how your health care dollars are spent.

The following example illustrates the potential savings when you use Great-West PPO effectively. It is simplified, because a typical Hospital stay would include various Physician fees and pharmacy bills. In this example, the Plan pays 80% for network services and 60% for non-network services.

Potential Savings When You Use Great-West PPO

	Network Provider	Non-network Provider
• Hospital Bill (Room and Board)	$1,600.00	$1,600.00
• Network Hospital Discount	$320.00	-0-
• Calendar Year Deductible	$250.00	$250.00
• Balance	$1,030.00	$1,350.00
• Plan Pays	$824.00 (80%)	$810.00 (60%)
• **Your Out-of-Pocket Cost (Co-payment plus deductibles)**	$456.00	$790.00

If you use a non-network provider, your out-of-pocket costs could be even higher if your Doctor fails to contact Medical Management.

Calendar Year Deductible

A calendar year deductible is the amount of covered medical expenses that you or a Dependent must incur before the Plan begins to pay benefits.

Benefits that are payable at 100% are not subject to this deductible and cannot be used to satisfy it.

Any co-pay amounts cannot be used to satisfy this deductible

Your Plan's calendar year deductible for medical benefits is $250 00 per person.

To limit your family's out-of-pocket expenses, the maximum deductible for you and all your covered Dependents is $750.00. No more than $250.00 per individual will be applied to the family deductible.

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines. These guidelines help control medical plan costs by setting a limit on the amount covered for each medical procedure.

- Providers under contract with Great-West agree to a set fee schedule for people enrolled in Great-West PPO When you see a Great-West PPO Network provider, or any other provider who is under contract with Great-West, the allowable covered expense will be the lesser of the actual billed amount and the amount allowed for the service under the negotiated fee schedule. The provider cannot bill you for any expenses in excess of the scheduled amount.
- When you see a provider who is not under contract with Great-West, the allowable covered expense will be determined by usual and customary charge guidelines. The usual and customary charge for each service or supply you receive will be the lesser of these two amounts:
  - The fee usually charged by your Doctor for these services and supplies.
  - The fee usually charged by other Doctors in the same geographical area for these services and supplies.

  You are responsible for any amounts that are more than usual and customary charges.

Maternity Coverage

Your maternity coverage includes prenatal care, childbirth, and post-natal care.

This Plan provides coverage for:

- a 48-hour Hospital stay for you and your baby following a normal vaginal delivery.
- a 96-hour Hospital stay for you and your baby following a cesarean section.

A Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for an early discharge is made by the attending Physician in consultation with the mother.

Pre-authorization is not required for the 48/96 hour Hospital stay as described above. However, you or your Doctor should still contact Member Services as soon as you find out that you are pregnant so they can help you identify and avoid risks during your pregnancy, obtain the prenatal care you need and direct you to appropriate facilities. ***Authorization is needed for a longer stay than as described above.***

■ Summary of Medical Benefits

The following chart is a brief summary of the medical benefits offered by your Plan. Please read the rest of this section for details about covered expenses, limitations and exclusions under the Plan.

Summary of Medical Benefits	
CALENDAR YEAR DEDUCTIBLE	
The calendar year deductible applies to all covered expenses except those payable at 100% and expenses subject to a co-pay .	
• Individual	$250.00
• Family	$750.00
PERCENTAGE PAYABLE	
Cost-Effective Services	
• Pre-admission Testing	100%
• Facility charges by a childbirth center	100%
• Home Health Care	100%
• Skilled Nursing Facility	100%
• Outpatient Surgery	100%
• Hospice Care	100%
Inpatient and Outpatient Hospital Care	
• Network Hospitals	80%
• Non-network Hospitals	60%

Summary of Medical Benefits *(Continued)*	
Physician charges for Surgery and Hospital Care	
• Network Physicians	80%
• Non-network Physicians	60%
Office Visits	
• Network Physicians	100% after $10.00 co-pay
• Non-network Physicians	60%
Well Newborn Care	
• Office Visits	
- Network Physicians	100% after $10.00 co-pay
- Non-network Physicians	60%
• Inpatient Hospital Care and Inpatient Surgery	
- Network Hospitals and Physicians	80%
- Non-network Hospitals and Physicians	60%
Emergency Room Treatment	
• If surgery is not performed	80%
• If surgery is performed	100%
TMJ Treatment	
• Office Visits	
- Network Physicians	100% after $10.00 co-pay
- Non-network Physicians	60%
• Inpatient Hospital Care and Inpatient Surgery	
- Network Hospitals and Physicians	80%
- Non-network Hospitals and Physicians	60%
Mental/Nervous Treatment	
• Inpatient Treatment	
- Network Hospitals and Physicians	80%
- Non-network Hospitals and Physicians	60%
• Outpatient Treatment	50%
Spinal Adjustment/Treatment	80%
Other Covered Expenses	80%
BREAKPOINT	
• Individual	$10,000 00

Summary of Medical Benefits *(Continued)*	
BENEFIT MAXIMUMS	
• Calendar year inpatient mental/nervous	30 days
• Calendar year outpatient mental/nervous	20 visits
• Lifetime outpatient occupational, speech and hearing therapy	$5,000.00
• Calendar year spinal adjustment and treatment	$500.00
• Calendar year acute nursing	$2,500.00
• Chemical dependency maximum in any one period of 24 consecutive months	$5,000.00
• Chemical dependency lifetime maximum	$10,000.00
• Maximum Benefit for ALL covered expenses (per covered person)	$1,000,000.00

What Medical Expenses Are Covered?

■ Cost-Effective Services

Inpatient Hospital stays are among the most expensive types of medical treatment. Fortunately, many unnecessary Hospital days can be avoided by using certain types of medical treatment we call cost-effective services. If you follow the guidelines set out below, these cost-effective services are payable at 100%, and you do *not* have to satisfy the calendar year deductible before the Plan begins paying benefits.

- Pre-admission Testing
- Facility Charges in Birthing Centers
- Home Health Care
- Care in a Skilled Nursing Facility
- Outpatient Surgery
- Hospice Care

Pre-admission Testing

Before you have surgery, you usually undergo a series of x-ray and lab tests. Having these tests done ***before*** you enter the Hospital will:

- Shorten your Hospital stay; and
- Lower your medical costs.

Pre-admission testing will be done in the outpatient department of a Hospital. To use this cost-saving feature:

- Make sure that the tests will be accepted by the Hospital where the surgery will be performed; and
- Have these tests performed within the seven-day period before your Hospital stay begins.

Facility Charges in Birthing Centers

Facility charges at a birthing center are also payable at 100%, and are not subject to the calendar year deductible. Facility charges do not include your Doctor's charges.

To receive 100% birthing center benefits, you must use a licensed birthing center. A Hospital birthing room does not qualify as a birthing center, unless it is a separate facility. Be sure to check with the Hospital before your admission to confirm that it has a separate birthing center.

Birthing centers provide:

- A comfortable, home-like atmosphere.
- A licensed registered nurse or midwife nurse practitioner in attendance with a Doctor on call.
- Access to Hospital facilities in case of complications.

Home Health Care

There are many instances in which a patient might prefer home health care to an inpatient Hospital stay. Such patients typically need a certain level of medical care, but not the full-time supervision of a Hospital staff.

When prescribed as an alternative or as a follow-up to inpatient Hospital care, medical services provided in the home by a licensed home health care agency are covered as a cost-effective service.

The Plan will pay for one home health care visit per day, up to 130 home health care visits each calendar year.

Skilled Nursing Facility Expenses

If you no longer need the level of care provided in the Hospital but are not yet well enough to go home, you may be admitted to a skilled nursing facility.

- The total covered expense for each day in a skilled nursing facility is limited to the usual charge of the facility for semi-private care. This daily covered amount includes room and board and all other services; and

- This covered daily amount will be percentages of the Hospital daily room and board amount allowed for confinement in the last Hospital in which the patient was confined before his admission to the skilled nursing facility. The percentages to be applied are as follows:
  - 50% for each of the first 60 days;
  - 25% for each of the next 30 days.

The Plan will pay for up to 90 days of care in a skilled nursing facility each calendar year.

To receive skilled nursing facility benefits, you must be sure that the skilled nursing facility you choose is licensed by the state as a skilled nursing facility. In addition, confinement in a skilled nursing facility must.

- Start within seven days after the end of a Hospital confinement. The Hospital confinement must have lasted at least three days.
- Be necessary for treatment of the same condition that caused the Hospital confinement. This must be certified by the patient's Doctor.
- Not be chiefly for the kind of care that helps a person perform the activities of daily living.

Outpatient Surgery

Many procedures such as minor knee surgery, simple hernia repairs, minor gynecological procedures, even cataract removals are routinely and safely performed on an outpatient basis. If outpatient surgery is performed in a surgical center or in the outpatient department of a Hospital, it is payable at 100% and is not subject to the calendar year deductible.

If you have outpatient surgery, your Doctor will release you on the same day surgery is completed. This lets you recover in the comfort of your home.

To be considered a surgical center, a facility must:

- Have an organized staff of Doctors.
- Have permanent facilities that are equipped and operated mainly for surgical procedures.
- Have a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care after care in the center.
- Not allow patients to stay overnight.
- Provide continuous services of Doctors and registered nursing services while the patient is in the center.
- Meet any licensing requirements of your state, if your state licenses outpatient surgery centers.

If you have surgery in a Doctor's office, it is payable as described in "Physician Charges For Surgery Or Hospital Care."

Hospice Care

Hospice care can provide the physical, psychological, spiritual or social support needed to help terminally ill patients cope with their illnesses. Hospice care includes services provided by a hospice care program in the patient's home, a Hospital or a hospice These services are covered as long as they are prescribed by a Doctor, and the covered person's life expectancy is six months or less.

A bereavement benefit up to $100.00 is included for expenses incurred by the patient's family for supportive services provided to them after the death of the patient.

Hospice care is payable at 100% and is not subject to the calendar year deductible.

■ Care Received in a Hospital

Covered expenses for care received in a Hospital include charges for room and board as well as other inpatient and outpatient services and supplies.

- For room and board, the covered expense for each day of confinement is limited to the Hospital's usual charge for semi-private care.
- For confinement in an intensive care unit, the covered expense for each day is limited to the Hospital's usual charge for confinement in an intensive care unit.

Benefits for emergency room treatment are described later in this booklet. (See "Treatment in An Emergency Room".)

Network Hospitals

Covered expenses for care received in a Great-West PPO Hospital are payable at 80% after the calendar year deductible.

Non-network Hospitals

After satisfaction of the calendar year deductible, Hospital charges are payable at 60%.

Things You Can Do to Help Control the Cost of Your Hospital Treatment

Most Hospital treatment is planned. Since you know about this treatment in advance, you have the opportunity to plan carefully and see that you receive the best coverage There are two things to consider:

- Can you use a Great-West PPO Hospital? You'll usually receive a higher level of benefits and will have less paperwork to worry about if you do.

- Is your Physician a Great-West PPO provider? If the answer is yes, your Doctor will call Medical Management when required. If the answer is no, make sure you receive pre-treatment authorization prior to receiving care (See "How Does Medical Management Work?")

All care received in a Hospital is subject to the calendar year deductible. However, you'll usually receive a higher level of benefits when you use Great-West PPO Hospitals.

■ Physician Charges For Surgery Or Hospital Care

If you are admitted to a Hospital, you may incur Physician or surgeon charges that are separate from your Hospital bill. These fees - along with charges for surgeries performed in a Doctor's office - are covered under this category of benefits.

If outpatient surgery is performed in a surgical center or in the outpatient department of a Hospital, it is payable as a cost-effective service.

Network Physicians

Fees charged by network Physicians are payable at 80% after the calendar year deductible.

Non-network Physicians

Fees charged by non-network Physicians are payable at 60% after the calendar year deductible.

■ Office Visits

Covered expenses for office visits include expenses for most services and supplies (x-rays, lab tests, drugs) provided in the Doctor's office. However, lab and x-ray expenses incurred during an office visit, sent to an independent lab/x-ray facility, and billed by the lab are paid subject to deductible and coinsurance. Office visits do not include surgeries performed in a Doctor's office.

Expenses for office visits are payable as follows:

Network Physicians

You only pay a $10.00 co-pay for each office visit to a Great-West PPO Physician. The balance of the office visit is payable at 100%. You do *not* have to satisfy the calendar year deductible before these benefits are payable.

Non-network Physicians

Office visits to non-network Physicians are payable at 60% after the calendar year deductible.

■ Well Newborn Care

Of course, babies who are born with medical problems are covered as any other Dependent under this Plan. But even healthy babies may receive medical care, so this Plan also includes benefits to give your healthy baby a good start in life. Covered expenses for well newborn care include Hospital and Physician charges for infant care through the first seven days of life.

To receive this benefit you must have Dependent coverage.

Network Hospitals and Physicians

For each well newborn care office visit to a Great-West PPO Physician, you pay only the $10.00 co-pay The balance of the office visit is payable at 100%. You do *not* have to satisfy the calendar year deductible before these benefits are payable.

For inpatient Hospital care and inpatient surgery, benefits are payable at 80% after the calendar year deductible.

Non-network Hospitals and Physicians

After satisfaction of the calendar year deductible, non-network treatment is payable at 60%.

■ Treatment in an Emergency Room

Charges for emergency room treatment are covered under a separate benefit that includes both facility and Physician fees.

If surgery is not performed in the emergency room, covered facility and Physician charges in a Hospital emergency room are payable at 80% after the calendar year deductible.

If surgery is performed, emergency room treatment is covered at 100%.

■ Treatment of TMJ and Related Disorders

This Plan covers treatment of craniofacial muscle disorders and temporomandibular disorders.

This treatment includes exams and diagnostic x-rays, muscle injections, nerve block injections and manipulation under anesthesia.

No amount will be paid for:

- grinding the surface of the teeth, splints and appliances, orthodontic treatment (such as braces or wires),
- change of vertical dimension, including crowns,
- any other treatment, services or supplies which are not covered under the Dental portion of this plan.

Network Hospitals and Physicians

For each office visit to a Great-West PPO Physician for TMJ treatment, you pay only the $10.00 co-pay. The balance of the office visit is payable at 100%. You do *not* have to satisfy the calendar year deductible before these benefits are payable.

For inpatient Hospital care and inpatient surgery, benefits are payable at 90% after the calendar year deductible.

Non-network Hospitals and Physicians

Non-network treatment is payable at 80% after the calendar year deductible.

■ Treatment of Mental/Nervous Conditions

The mental/nervous benefit provides coverage for mental health services. This benefit includes coverage for both inpatient and outpatient treatment.

Inpatient Treatment

Covered expenses for inpatient treatment are payable at:

- 80% after the calendar year deductible if provided in a Great-West PPO Hospital or by a Great-West PPO Physician; or
- 60% after the calendar year deductible if provided in a non-Great-West PPO Hospital or by a non-Great-West PPO Physician.

The Plan will pay up to 30 days in any calendar year.

Outpatient Treatment

Covered expenses for outpatient treatment by a Doctor are payable at 50% after the calendar year deductible.

The Plan will pay up to 20 visits in any calendar year.

Outpatient treatment is payable on the same basis whether or not the Physician is a member of the Great-West PPO Network.

■ Treatment Of Chemical Dependency

This benefit provides coverage for treatment of chemical dependency. This benefit includes coverage for:

- Inpatient treatment during confinement for a covered person in:
  - A Hospital, as defined in the glossary of this booklet; or
  - A Chemical Dependency Treatment Facility, as defined below

  Inpatient treatment will include detoxification.
- Out-patient treatment for a covered person:
  - In the out-patient department of a Hospital as defined in the glossary of this booklet; or

- By a Doctor; or
- In a Chemical Dependency Treatment Facility, as defined below.

As used in this section, the term:

- "Chemical Dependency Treatment Facility" means a facility which has been approved by the office or department responsible for granting approval of such facilities in the geographical area in which the treatment is rendered.
- "Chemical Dependency" means an Illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverage It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Subject to the limitations and maximums set out below, benefits for treatment of chemical dependency will be payable in the same way as for any other Illness

Benefits for the treatment of chemical dependency.

- Will be exclusive of any deductibles, coinsurance and copayments
- In any one period of 24 consecutive months will be payable up to but not exceeding $5,000 00. This amount may be reduced by the benefits paid by any plan for the treatment of chemical dependency in the immediately preceding 24 consecutive month period
- Will be limited to a lifetime maximum of $10,000.00.

■ Spinal Adjustment and Treatment

Covered expenses for services related to spinal adjustment are payable at 80% after the calendar year deductible.

Up to $500.00 is payable in any calendar year.

No benefits are payable for massage.

Spinal adjustment is payable on the same basis whether or not the Physician is a member of the Great-West PPO Network.

■ Other Covered Medical Expenses

Other covered medical expenses are payable at 80% after the calendar year deductible. These expenses include:

- Outpatient Occupational, Speech and Hearing Therapy.

- Other Medical Services and Supplies

Outpatient Occupational, Speech and Hearing Therapy

For outpatient services of licensed occupational, speech and hearing therapists:

- Benefits are payable at 80% after the calendar year deductible.
- Up to $5,000.00 is payable during the entire time the person is covered under this medical Plan.

Therapy provided during an inpatient Hospital stay is payable on the same basis as other inpatient Hospital care.

Other Medical Services and Supplies

Medical services and supplies include.

- Nursing services. These include nursing services on an in-home basis which, in any one calendar year, will not exceed the Calendar Year Benefit Maximum of $2,500.00 for In-Home Acute Nursing Services.
- Medical equipment.
- Physical therapy.
- Ambulance services
- Prescription drugs, except oral contraceptives, when received as an outpatient.

  If you purchase drugs at a PCS pharmacy and use your ID card, you will receive preferred pricing from the pharmacy and the pharmacy will file your claim electronically.
- Services and supplies required for the treatment of diabetes and diabetes self-management education programs.
- When required as a result of a mastectomy, reconstructive surgery (payable on the same basis as any other surgery) and any prosthetic device.

■ Alternate Care and Treatment

Hospital confinement is not always the best environment for treating an Illness. For a patient who needs significant long-term medical supervision, Medical Management may recommend alternative care and treatment.

The Case Management (CM) program helps patients manage their health care. The goal of the CM program is to develop alternative treatment plans that will help patients obtain the type of care they need *outside* of a Hospital setting. A patient who chooses to participate in this program is assigned a case manager, who will help coordinate the patient's care.

As a part of the pre-treatment authorization or CM program, Great-West may recommend alternate treatment plans or facilities that:

- Are not included in this medical Plan; or
- Are included in this medical Plan, but on a basis that differs from the care and treatment being recommended by Great-West.

If you and your Doctor decide that the recommended alternative treatment plan is right for you, these expenses are payable on the same basis as the care and treatment for which they are substituted.

Great-West may authorize coverage for such alternate forms of care and treatment without obtaining prior consent from your Employer.

What's Not Covered?

■ Pre-Existing Conditions Limitation

This section will *not* apply to a child placed with you for adoption.

A pre-existing condition is an Illness or any related condition for which you or your Dependent received services, supplies or medication during the 3 months before the enrollment date for you or your Dependent under this medical Plan

A pre-existing condition is not.

- A pregnancy existing on the enrollment date
- Genetic information

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received after:

- You or your Dependent has not received services or medication for this condition for 3 months, or
- 12 months after the enrollment date for you or your Dependent.

If you are a late applicant as described in the section, "What If I Don't Apply For Coverage When I'm First Eligible?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 18 months after your enrollment date.

"Enrollment date" means:

- for an Employee who applies for coverage for himself or herself during the 31-day period after first becoming eligible to do so (the Employee's initial application period), the first day of the Employee's Service with the Employer
- for an eligible Dependent for whom application for coverage is made during the 31-day period after the Employee's initial application period, the first day of the Employee's Service with the Employer.

- for a late applicant or special enrollee (as described in the section, "What If I Don't Apply For Coverage When I'm First Eligible?"), or for any newly acquired Dependent, the date the person becomes covered under this Plan

Portability of Coverage

A person (you or your Dependent) will receive credit toward satisfaction of the Pre-Existing Condition Limitation described in this section for the time he was covered under another health plan, but only if:

- Your Service begins after the effective date of this Plan; and
- The person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 62-day period just before his or her enrollment date under this Plan.

  Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 62-day period.

If the person was covered for a period of time under Creditable Coverage that is:

- greater than or equal to the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- less than the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

  However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

"Creditable Coverage" is defined as coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived

■ General Benefit Limitations

The following limitations apply to all medical treatment you receive.

Benefits are payable only if the medical expenses are for treatment that is:

- Medically Necessary; and

- Except for well newborn care, required as a result of symptoms of Illness; and
- Recommended, performed or prescribed by a Doctor; and
- *The least expensive, medically acceptable service or supply, as determined by* Great-West, and
- *Incurred while you or your Dependent is covered for these medical benefits* Treatment is considered to be incurred on the date the service is rendered or the supply is provided. No benefits are payable for expenses incurred after termination of coverage except as provided in the Extended Benefits provision of this booklet. See "When Coverage Begins and Ends" (Eligibility).

No amount will be payable for.

- An accidental injury that occurs while working for pay or profit.
- A sickness for which the covered person is entitled to benefits under any Worker's Compensation or similar law, whether or not he or she has declined participation under the law. This limitation for sickness does not apply to proprietors, partners or executive corporate officers of the Employer.
- Services or supplies:
  - Provided by any government health plan, or
  - For which there would be no cost to the covered person if he or she did not have coverage

  Benefits payable under this medical Plan will not be reduced or denied because the covered person is entitled to benefits under a state-sponsored medical assistance program, but those benefits will be paid to the state. Any amount the Plan pays:
  - Will be considered benefits paid under this medical Plan, and
  - *Will constitute a full discharge of the Plan's liability to the extent of the* payment.
- Expenses that are incurred.
  - For treatment provided by your spouse, children, brothers, sisters, parents or grandparents, or
  - For treatment provided by your spouse's children, brothers, sisters, parents or grandparents.
- Cosmetic surgery and all expenses related to the surgery, unless the operation is performed or the treatment is rendered to correct:
  - Deformities that result from Illness, or

- Congenital defects that interfere with bodily but not psychological function; or
- Any congenital defect of a newborn child

- Any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT).
- Infertility testing.
- Tubal ligations.
- Vasectomies.
- Experimental or Investigational treatment or procedures.
- Custodial care. "Custodial care" means the kind of care that helps you perform the activities of daily living, such as, but not limited to.
  - Help in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet.
  - Preparation of special diets.
  - Housekeeping.
  - Supervision of medication which.
    * Does not need the continuing attention of trained medical or paramedical personnel; and
    * Can usually be administered by yourself, a member of your family, or any other person who has not had formal medical training.
- Radial keratotomy.
- The reversal of any sterilization procedure.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Hearing aids or the fitting of hearing aids.
- Dental services other than treatment of accidental injuries to natural teeth within six months after the Accident. Chewing Injuries are not considered accidental injuries.
- Services and supplies received for an Illness that is a result of war, declared or undeclared.
- Non-prescription drugs or medicines, or drugs or medicines that are not approved under the United States Food and Drug Act or its successor(s)
- Anti-obesity drugs and formulas.

- Special nursing services if those same services are provided by the regular nursing staff of any Hospital in which the patient is confined.
- Charges by a Doctor for any phone call or interview during which the patient is not examined.
- Smoking cessation programs
- Oral contraceptives

Do I Have Protection Against High Out-of-Pocket Expenses?

To help protect you and your family against high health care expenses, your Employer has set a breakpoint for your Plan. A breakpoint is the level of covered expenses at which you will receive 100% benefits.

■ Calendar Year Breakpoint

Your Plan's calendar year breakpoint is $10,000.00. This means that if covered expenses for you or one of your Dependents reach $10,000.00 in any one calendar year, all other covered expenses for that person during the rest of that calendar year will be payable at 100%.

Covered expenses for outpatient treatment of mental/nervous conditions will *not* be payable at 100% even if you have reached your breakpoint.

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the breakpoint for that year will also be applied to the breakpoint for the next calendar year.

■ Expenses That Do Not Count Toward the Breakpoint

The following medical expenses will not be used to satisfy your individual breakpoint.

- Covered expenses used to satisfy any deductible or co-pay amounts.
- Covered expenses for outpatient treatment of mental/nervous conditions.
- Covered expenses that are payable at 100%
- Expenses for services and supplies not covered under this Plan.

Is There a Limit on the Amount of Medical Benefits I Can Receive?

The provision entitled "What Medical Expenses Are Covered?" describes the calendar year and lifetime benefit maximums that apply to specific types of covered expenses. This medical Plan also includes an overall maximum benefit that applies to all covered expenses.

The maximum amount payable for any one person is $1,000,000.00 during the entire time he or she is covered under this medical Plan.

How Are My Benefits Affected When My Employer Transfers Medical Claims Processing to Great-West?

During the calendar year that your Employer transfers medical claims processing to Great-West, your claims will be paid on the following basis:

■ Deductible Credits

Any amount you've already paid toward the medical deductible under the prior medical plan will be applied to this Plan's deductible.

■ Breakpoint Credits

Any amount of covered expenses you've already used to satisfy any breakpoint under the prior medical plan will be applied to this Plan's breakpoint.

■ Special Benefits for Pre-Existing Conditions

This transfer provision includes special benefits for you if you or your Dependent had a pre-existing condition at the time your coverage was transferred to Great-West. If you or your Dependent:

- Would otherwise be ineligible for coverage under this Plan because of the pre-existing conditions limitation; and
- Is not eligible for benefits under your prior plan because of a contractual limitation or exclusion of benefits for expenses incurred after termination of that plan;

then you or your Dependent will be eligible for benefits that are the lesser of:

- The amount that would have been paid under the prior plan if it had stayed in force; and
- The amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

If coverage transfers to Great-West within 90 days from the time your coverage terminated under a prior carrier and coverage under a prior carrier was "Qualifying prior coverage", then:

- You or your Dependent will be eligible to receive credit toward the pre-existing conditions limitation referred to in this medical Plan, if you or your Dependent were covered under the prior plan for less than 3 months The pre-existing conditions waiting period referred to in this provision will be reduced by the number of consecutive months you or your Dependent were covered under the prior plan.
- You or your Dependent will not be required to satisfy the pre-existing conditions limitation referred to in this medical Plan, if you were covered under the prior plan for longer than 3 months

  The term "Qualifying prior coverage" will include

  - A plan that is substantially similar to this Plan
  - A self-funded plan, including a state or local government self-funded plan.
  - The Uniform Plan
  - The Basic Health Plan
  - The Washington State Health Insurance Pool.
  - Medicaid.

Effect of Transfer on Benefit Maximums

Any calendar year benefit maximum under this Plan will be reduced by the amount paid under the prior plan in the calendar year in which your Employer transfers claims processing to Great-West.

How Will Benefits Be Affected By Medicare?

If you are an active Employee and you or your Dependents become eligible for Medicare due to age or disability, you and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan Your benefits will not be reduced by any Medicare benefit you or your Dependents receive Instead, this Plan will coordinate benefits with Medicare.

Unless you choose otherwise, your coverage under this medical Plan will be considered your primary coverage, and Medicare will be considered your secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.

If you choose Medicare as your primary coverage, you will lose all coverage under this medical Plan. See your Employer for details

■ If You or a Covered Dependent Becomes Eligible for Medicare Due to End-Stage Renal Disease

For the first 30 months of treatment for End-Stage Renal Disease (ESRD), your coverage under this medical Plan will be the primary coverage. After that, Medicare will become the primary coverage

Where To Find The Answers To Your Questions

GREAT-WEST POS PRESCRIPTION DRUG BENEFITS

- **How Do My Prescription Drug Benefits Work under the Great-West POS Plan?**
  - Summary of Prescription Drug Benefits 1
  - Concurrent Drug Utilization Review 1
- **How Do I Use the Preferred Pharmacy Program?**
  - What If I Don't Have My ID card with Me? 2
  - What If I Buy a Prescription Drug at a Non-Network Pharmacy? 3
- **How Do I Use the Mail Service Prescription Drug Program?**
  - How Do I Order Refills? 4
  - What If I Need Medication Immediately? 4
- **What Prescription Drug Expenses Are Covered?**
  - Preferred Pharmacy Program 5
  - Mail Service Prescription Drug Program 5
- **What's Not Covered?**
  - General Benefit Limitations 5

How Do My Prescription Drug Benefits Work under the Great-West POS Plan?

There are two aspects to your prescription drug program

- Preferred Pharmacy Program - This program uses a nationwide network of participating PCS pharmacies. Because network pharmacies have agreed to limit their charges to persons covered under the Preferred Pharmacy Program, your out-of-pocket costs will usually be lower if you use pharmacies in this network. You can obtain information about network pharmacies by calling Great-West's toll-free Member Services number on your I D. card.
- Mail Order Drug Program - This program lets you order larger quantities of maintenance drugs through the mail to lower your out-of-pocket costs

■ Summary of Prescription Drug Benefits

The following chart is a brief summary of the prescription drug benefits offered by your Plan. Please read the rest of this section for details about covered expenses, limitations and exclusions under the Plan.

Summary of Prescription Drug Benefits	
Preferred Pharmacy Prescription Drugs	
Percentage Payable	
• If you use a network pharmacy	
- Generic Drugs	100% after $10 00 co-pay
- All Other Drugs	100% after $15 00 co-pay
• If you do not use a network pharmacy	
- Generic Drugs	50% after $10.00 co-pay
- All Other Drugs	50% after $15.00 co-pay
Mail Service Prescription Drugs	
Percentage Payable	
• Generic Drugs	100% after $10.00 co-pay
• All Other Drugs	100% after $15.00 co-pay

■ Concurrent Drug Utilization Review

The Preferred Pharmacy Program has been designed to help ensure that you receive clinically and economically sound pharmaceutical care.

The network pharmacies and the mail order drug program are linked electronically to a computer system that contains information about drugs you have received while covered under this Plan. Each time you present a prescription to be filled, this system is checked for:

- Drug interactions.
- Therapeutic duplications.
- Early refill and excessive use.
- Excessive/insufficient drug doses.
- Drug/disease, drug/age and drug/pregnancy interactions

How Do I Use the Preferred Pharmacy Program?

The Preferred Pharmacy program uses a network of pharmacies that are linked to an electronic claims system called RECAP. All participating network pharmacies have agreed to limit their charges to persons covered under the Preferred Pharmacy Program, which usually means lower out-of-pocket costs to you.

Because these pharmacies have access to your Plan information, they know exactly how much you should pay for each prescription. Processing claims electronically at the time of purchase eliminates claim forms, which means you don't have to wait for reimbursement.

Your ID card is the key to fast, convenient claims service and low out-of-pocket costs.

- Present your ID card when purchasing drugs at any network pharmacy.
- The pharmacy will ask you to sign a claim voucher, which lets them process your claim
- Pay the pharmacist your co-pay for each prescription or prescription refill. Your Plan's co-pay is $15.00 for name brand drugs and $10.00 for generics.

Example: For a generic prescription that costs $20.00, you pay the $10.00 co-pay. Your Plan pays the remaining $10.00 directly to the pharmacist.

■ What If I Don't Have My ID card with Me?

If you don't have your ID card with you when you fill a prescription at a network pharmacy, you will pay the full price for the prescription and must file a claim to be reimbursed.

During the first 60 days you are covered for prescription drug benefits under this Plan, if you don't use your ID card your reimbursement will be the retail price of the drug less your co-pay PCS will send this reimbursement directly to you.

However, after you have been covered for 60 days, if you don't bring your ID card with you, your reimbursement will be the PCS negotiated pharmacy discount price less your co-pay. PCS will send this reimbursement directly to you. Your cost, which is retail price, is almost always greater than the PCS negotiated pharmacy discount price. You will not be reimbursed for the difference between retail price and PCS negotiated discount price. That's why it's important to bring your ID card with you when you purchase drugs.

■ What If I Buy a Prescription Drug at a Non-Network Pharmacy?

If you purchase drugs at a non-network pharmacy, the Plan pays 50% of the covered charges for drugs after the co-pay. Your Plan's co-pay is $15.00 for name brand drugs and $10.00 for generics.

If the Pharmacy Is a PCS Pharmacy

If you present your ID card at a non-network PCS pharmacy, you must pay the pharmacist your co-pay for each prescription or prescription refill, plus an amount equal to 50% of the remainder of the covered charges for the drug.

If the Pharmacy Is Not a PCS Pharmacy, or If You Don't Have Your ID card with You

When you purchase drugs at a non-network pharmacy that is ***not*** a PCS pharmacy, or if the pharmacy ***is*** a PCS pharmacy but you do not bring your ID card, you must pay the full price of the prescription and file a claim to be reimbursed.

- Ask your Employer for a Prescription Drug Claim form
- Complete this claim form, attach your prescription drug receipt, and mail it to the address printed on the form.
- PCS will send the reimbursement directly to you.

After the co-pay, the amount of your reimbursement will be 50% of the remainder of the covered charges for the prescription drug had you used a network pharmacy If your pharmacy charges more for a prescription drug than a network pharmacy would charge, you will have to pay the difference.

How Do I Use the Mail Service Prescription Drug Program?

The mail service prescription drug program is for people who require maintenance prescription drugs on a long-term basis. With this program, you may buy up to 90-day supplies of insulin and other covered prescriptions through the mail.

Medications are distributed by a mail order service program. The drugs you receive through this program are the same name brands or generic equivalents that you would otherwise purchase in a pharmacy When you purchase drugs through this program, you pay only a $15 00 co-pay for name brand drugs. If you buy a generic drug, your co-pay is $10.00.

- Ask your Doctor to prescribe needed medications for a 90-day supply, plus refills If you are presently taking medications, ask your Doctor for a new prescription.
- Ask your Employer for a mail service program brochure. Complete the member profile form found in the brochure with your first order only. Be sure to answer all the questions for yourself and your Dependents. Make certain you include your ID card Number on the form.
- Send the completed member profile form, your original prescription(s) and the co-pay for each prescription to the mail order service program. Your Employer can give you a pre-addressed order envelope to use.
- The mail order service program will process your order and return your medications to you by First Class Mail or UPS, along with re-order instructions for future prescriptions and/or refills. Allow 14 days for delivery.

  If your prescription is for a brand name drug but a generic equivalent is available, you will be sent the generic drug unless your Doctor has written DAW (Dispense as Written) on the prescription.

How Do I Order Refills?

- With your original prescription medication, you will receive a notice showing the number of times it may be refilled.
- Simply mail this notice, along with your co-pay, to the mail order service program in the pre-addressed order envelope.
- To avoid the risk of running out, order your refills at least two weeks before you need them
- You may also request refills by calling the Customer Service Toll Free Number printed on the member profile form.

What If I Need Medication Immediately?

Obviously, there will be times when you need a prescription immediately. On these occasions, you should have your prescription filled at a local PCS participating pharmacy Be sure to use your ID card.

If you need medication immediately, but will be taking it on an ongoing basis, ask your Doctor for two prescriptions.

- The first should be for a 14-day supply that you can have filled at a local PCS participating pharmacy.
- The second prescription should be for the balance, up to a 90-day supply Send it, with your co-pay, to the mail order service program immediately

What Prescription Drug Expenses Are Covered?

■ Preferred Pharmacy Program

If you use a network pharmacy, covered expenses for prescription drugs are payable at 100% after your co-pay.

If you use a non-network pharmacy, covered expenses for prescription drugs are payable at 50% after your co-pay

Covered expenses include charges for

- Drugs and medicines that:
  - Require the written prescription of a Doctor; and
  - Are purchased from a licensed pharmacist or from a Doctor who is licensed to dispense drugs, and
  - Are required in the treatment of Illness.
- Insulin.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. However, the brand name drug will be considered a covered expense if a generic drug is not available, or if the Doctor writes DAW (Dispense as Written) on the prescription. If you request a brand name drug when a generic drug is available, and the Doctor has not written DAW on the prescription, then, in addition to the generic drug co-pay, you must pay the difference between the cost of the generic drug and the brand name drug

■ Mail Service Prescription Drug Program

Covered expenses for prescription drugs are payable at 100% after the co-pay. Covered expenses include costs for home delivery and expenses for

- Prescription maintenance drugs. "Prescription maintenance drugs" means drugs prescribed by your Doctor on an ongoing basis. The mail service prescription drug program covers drugs required for treatment of Illness.
- Insulin.

What's Not Covered?

■ General Benefit Limitations

The following limitations apply to all prescription drugs you receive

Benefits will be payable only if the covered prescription drugs are:

- Received while you or your Dependent is covered for these prescription drug benefits; and
- Recommended and prescribed by a Doctor

No amount will be payable for:

- Under the Preferred Pharmacy prescription drug program, that part of a single purchase of any drug or medicine that exceeds a 34-day supply.
- Under the mail service prescription drug program, that part of a single purchase of a prescription maintenance drug or insulin that exceeds a 90 day supply.
- More than one purchase of a drug, medicine or insulin during the dosage period recommended by the prescribing Doctor
- Drugs, medicines, or insulin that:
  - Are not approved under the United States Food and Drug Act;
  - Are dispensed in a quantity or an amount in excess of that specified by the prescribing Doctor,
  - Are dispensed more than one year after the date on which the drug, medicine, or insulin was ordered by the prescribing Doctor;
  - Are consumed or used or administered while the covered person is confined to a Hospital or similar institution that has on its own premises a facility for dispensing pharmaceuticals.
- Therapeutic devices and appliances, immunization agents, biological serums, blood or blood plasma.
- The administration of drugs, medicines, or insulin.
- Over-the-counter drugs and supplies.
- Anti-obesity drugs and formulas.
- Allergy serums.
- Oral contraceptives.
- Drugs for treatment of infertility.

Where To Find The Answers To Your Questions

DENTAL BENEFITS

- **How Do My Dental Benefits Work?**
  - Calendar Year Deductible 1
  - Usual and Customary Charges 1
  - Summary of Dental Benefits 1
- **What Dental Expenses Are Covered?**
  - Preventive Treatment 2
  - Basic Treatment 2
  - Major Treatment 3
- **What's Not Covered?**
  - General Benefit Limitations 4
- **Can I Find Out How Much I Have to Pay Before I Receive Treatment?**
  - Submitting a Treatment Plan 7
- **Is There a Limit on the Amount of Dental Benefits I Can Receive?**
  - Preventive/Basic/Major Annual Maximum 7

How Do My Dental Benefits Work?

Your Plan offers dental benefits so that you and your family can enjoy good oral health.

Covered dental treatment is broken down into these categories:

- ***Preventive Treatment*** - Includes routine checkups and other dental maintenance
- ***Basic Treatment*** - Includes minor dental procedures, such as filling teeth.
- ***Major Treatment*** - Includes extensive dental work.

■ Calendar Year Deductible

A calendar year deductible is the amount of covered dental expenses that you or a Dependent must incur in a calendar year before the Plan begins to pay benefits. Benefits payable at 100% are not subject to this deductible.

Your Plan's calendar year deductible for dental benefits is $100.00 per person.

■ Usual and Customary Charges

All dental benefits are subject to usual and customary charge guidelines. Usual and customary charge guidelines help control plan costs by setting a limit on the amount covered for each dental procedure.

The usual and customary charge for each service or supply you receive will be the lesser of these two amounts.

- The fee usually charged by your Dentist for these services and supplies.
- The fee usually charged by other Dentists in the same geographical area for these services and supplies.

You are responsible for any amounts that are more than usual and customary charges.

■ Summary of Dental Benefits

The following chart is a brief summary of the dental benefits offered by your Plan Please read the rest of this section for details about covered expenses, limitations and exclusions under the Plan.

Summary of Dental Benefits	
CALENDAR YEAR DEDUCTIBLE	
The calendar year deductible applies to all covered expenses except those payable at 100%.	
• Individual	$100 00

Summary of Dental Benefits *(Continued)*	
PERCENTAGE PAYABLE	
• Preventive Treatment	100%
• Basic Treatment	80%
• Major Treatment	50%
BENEFIT MAXIMUMS	
• Annual Maximum (for Preventive, Basic and Major Treatment)	$1,000.00

What Dental Expenses Are Covered?

Dental treatment is broken down into three categories. The following describes the expenses covered under each category.

■ Preventive Treatment

With regular dental care, you and your family can avoid more extensive and costly treatment later. If you follow the guidelines set out below, most routine dental care is payable at 100% and you do not have to meet the calendar year deductible before the Plan begins paying benefits

You and each of your covered Dependents may receive the following services twice each calendar year, but not more than once in any five-month period:

- Oral examination.
- Cleaning of teeth
- Bite wing x-rays.
- Topical application of fluoride solution for Dependent children.

Preventive treatment also includes:

- sealants for children; and
- a full-mouth series of x-rays once in any 24-month period.

■ Basic Treatment

Basic treatment is payable at 80% after the calendar year deductible.

Basic treatment includes:

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic, and composite fillings. Silicate, acrylic, and composite fillings are covered only for teeth in front of the first bicuspid.
- Dental surgery.

- X-ray and laboratory procedures required for dental surgery.
- General anesthesia required for dental surgery.
- Treatment for relief of dental pain.
- Drugs and medicines that require a Dentist's written prescription, including the cost of medication and its administration, if it is given at your Dentist's office.
- For children age 14 and under, space maintainers for missing primary teeth and habit-breaking appliances.
- Consultations required by the attending Dentist.
- Relines and rebases to existing dentures
- Endodontic Treatment.
- Periodontic Treatment.

■ Major Treatment

Major treatment is payable at 50% after the calendar year deductible

Major treatment includes:

- Crowns, inlays and onlays.
- Fixed bridge restorations
- Removable partial or complete dentures. This includes denture replacement
- Relines and rebases to existing dentures

Benefit Details for Major Treatment

The following further explains what services and supplies are covered under major treatment:

- Initial placement of full or partial dentures or bridgework, including abutments.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
  - The existing appliance cannot be repaired or restored to use, and
  - At least five years have passed since the last placement, or
  - The replacement:
    * Replaces an existing temporary appliance that was placed after the date on which the person became covered; and
    * Is placed within 12 months after a temporary appliance was placed, or
    * The replacement.

- Is needed because of the pulling of additional natural teeth or accidental injuries to natural teeth while covered, and
- Is completed within 12 months of the extraction or Accident.

If you have a partial denture, and a natural tooth adjacent to that denture is pulled while you are covered, the addition of another tooth to your denture is covered.

Chewing injuries are not considered accidental injuries.

What's Not Covered?

General Benefit Limitations

The following limitations apply to all dental treatment you receive.

Benefits are payable only if the covered dental expenses are for treatment that is:

- Incurred and completed while you or your Dependent is covered for these dental benefits
- Provided by:
  - A licensed Dentist.
  - A licensed Doctor.
  - A dental assistant or a dental hygienist working under the direct supervision of a Dentist.
- Provided according to generally accepted dental practice.
- Necessary for the diagnosis, prevention or correction of dental disease, defect or injury.
- The least costly procedure that will, as determined by Great-West, produce a professionally satisfactory result.

No amount will be payable for:

- An accidental injury that occurs while working for pay or profit.
- A sickness for which the covered person is entitled to benefits under any Worker's Compensation or similar law, whether or not he or she has declined participation under the law. This limitation for sickness does not apply to proprietors, partners or executive corporate officers of the Employer
- Dental treatment:
  - Provided by any government health plan; or
  - For which there would be no cost to the covered person if he or she did not have coverage.

- Dental treatment received from a dental or medical department maintained by any of the following:
  - Your Employer,
  - A mutual benefit association,
  - A labor union;
  - A trustee,
  - Any other similar group.
- Dental treatment that is required as the result of war, declared or undeclared.
- Broken appointments or the completion of claim forms.
- Appliances which have been lost, mislaid or stolen.
- Dental treatment that:
  - Is cosmetic in nature; or
  - Does not have general professional endorsement.
- Experimental or Investigational treatment or procedure
- Orthodontic treatment.
- Dental treatment or services provided:
  - To correct any congenital defect or developmental malformation which does not interfere with function, or
  - For dietary planning for the control of dental caries; or
  - For plaque control; or
  - For oral hygiene instructions.
- Customized procedures, such as.
  - Implants,
  - Precision or semi-precision attachments;
  - Over dentures or customized prosthesis;
  - Duplicate sets of dentures;
  - Facings on crowns or pontics on molars.
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting
- Expenses that are incurred:
  - Before the effective date of coverage; or
  - After the date the coverage ends; or

- For covered dental treatment that is completed after the date coverage ends.

The date an expense is incurred means:

- For full or partial dentures, the date the final impression is made.
- For fixed bridges, crowns, inlays and onlays, the date the teeth are prepared.
- For root canal therapy, the date the pulp chamber is opened and explored to the apex.
- For periodontal surgery, the date the surgery is actually performed.
- For any other treatment, the date the service is provided.

The date on which treatment is completed means

- For full or partial dentures, the date the appliance is seated or inserted
- For fixed bridges, crowns, inlays and onlays, the date the restoration is cemented in place.
- For root canal therapy, the date the pulp chamber is sealed.
- For periodontal surgery, the date the surgery is actually performed.
- For any other treatment, the date the service is provided.

- Expenses that are incurred for treatment provided by:
  - Your spouse, children, brothers, sisters, parents or grandparents; or
  - Your spouse's children, brothers, sisters, parents or grandparents.
- Dental treatment of craniofacial muscle disorders and temporomandibular disorders. TMJ is considered to result from disease of or injury to the temporomandibular joint. This joint is controlled by:
  - muscles on each side of the face and those in the back of the head and neck. These muscles open and close the jaw; and
  - the position of the teeth in the upper and lower jaw. The teeth determine how far the hinge will close.
- However, when associated with TMJ, Usual and Customary Charges for splints and appliances will be covered for a covered person who has attained age 19.
- Take-home fluoride solutions.
- Local analgesics
- That part of any covered dental expense that is payable under any other section of this booklet, unless:

- Benefits are payable under both this dental benefit and any medical benefits; and
- It is to the covered person's advantage to have benefits paid under dental benefits rather than under medical benefits

Can I Find Out How Much I Have to Pay Before I Receive Treatment?

■ Submitting a Treatment Plan

For all dental treatment expected to cost $300 00 or more, your Dentist should submit a treatment plan to your Great-West benefit payment office. This way, Great-West can advise you in advance how much you will have to pay for the proposed treatment.

- Ask your Dentist to prepare a treatment plan and send it to the Great-West benefit payment office listed on your ID card
- You and your Dentist will receive an explanation of benefits (EOB) that details the benefits payable under your Plan. This is called a predetermination of benefits
- A predetermination of benefits is good for 90 days. However:
  - You must be covered for dental benefits when treatment is received, and
  - The benefits payable are subject to all Plan maximums

If you do not receive treatment within 90 days of the date Great-West approves benefits, your Dentist should submit a new treatment plan.

Is There a Limit on the Amount of Dental Benefits I Can Receive?

■ Preventive/Basic/Major Annual Maximum

The maximum amount payable for preventive, basic and major treatment for a covered person in any one calendar year is $1,000.00

Where To Find The Answers To Your Questions

VISION BENEFITS

■ **How Do My Vision Benefits Work?**

Calendar Year Deductible 1

Summary of Vision Benefits 1

■ **What Vision Expenses Are Covered?**

Eye Examinations 1

Frames 2

Eyeglass Lenses 2

Contact Lenses 2

■ **What's Not Covered?**

General Benefit Limitations 2

How Do My Vision Benefits Work?

Your vision benefits provide coverage to you and your family for eye examinations, glasses and contact lenses. Benefits for vision expenses, up to certain maximums, are payable at 100%

■ Calendar Year Deductible

A calendar year deductible is the amount of covered vision expenses that you or a Dependent must incur before the Plan begins to pay benefits.

Under this Plan, there is no calendar year deductible.

■ *Summary of Vision Benefits*

The following is a brief summary of the vision benefits offered by your Plan. Please read the rest of this section for details about covered expenses, limitations and exclusions under the Plan

Summary of Vision Benefits	
CALENDAR YEAR DEDUCTIBLE	NONE
PERCENTAGE PAYABLE	
• Eye examinations	100%
• Frames	100%
• Lenses	100%
BENEFIT MAXIMUM (per 24 -month period)	
• Eye examinations	$65.00
• Frames	$90.00
• Single Vision lenses	$75.00
• Bifocal lenses	$92.00
• Trifocal lenses	$120.00
• Lenticular lenses	$128.00
• Contact lenses	
- cosmetic contact lenses	$80.00
- for special conditions	$240.00

What Vision Expenses Are Covered?

■ Eye Examinations

Benefits for eye examinations are payable at 100%, up to $65.00 in any period of 24 consecutive months.

■ Frames

Benefits for frames are payable at 100%, up to $90.00 in any period of 24 consecutive months.

■ Eyeglass Lenses

Benefits for eyeglass lenses are payable at 100%, up to $75.00 for single vision lenses, $92.00 for bifocal lenses, $120.00 for trifocal lenses and $128.00 for lenticular lenses in any period of 24 consecutive months. This maximum amount includes the cost of tinting, photograying and hardening of lenses.

■ Contact Lenses

Benefits for contact lenses for special conditions are payable at 100%, limited to a lifetime maximum of $240.00. Cosmetic contact lenses are payable at 100%, up to $80.00 for any period of 24 consecutive months

What's Not Covered?

■ General Benefit Limitations

The following limitations apply to all vision expenses.

Benefits will be payable only if the covered vision expenses are:

- Incurred while you or your Dependent is covered for these vision benefits. An expense is considered to be incurred on the date the service is rendered or the supply is provided.
- For services performed or supplies prescribed by a licensed ophthalmologist, a licensed optometrist or a qualified dispensing optician.

No amount will be payable for:

- An accidental injury that occurs while working for pay or profit.
- A sickness for which the covered person is entitled to benefits under any Worker's Compensation or similar law, whether or not he or she has declined participation under the law. This limitation for sickness does not apply to proprietors, partners or executive corporate officers of the Employer.
- Services or supplies:
  - Provided by any government health plan; or
  - For which there would be no cost to the covered person if he or she did not have coverage.

  Benefits payable under this vision Plan will not be reduced or denied because the covered person is entitled to benefits under a state-sponsored medical assistance program, but those benefits will be paid to the state. Any amount the Plan pays:

  - Will be considered benefits paid under this vision Plan; and
  - Will constitute a full discharge of the Plan's liability to the extent of the payment.
- Expenses that are incurred:
  - For treatment provided by your spouse, children, brothers, sisters, parents or grandparents; or
  - For treatment provided by your spouse's children, brothers, sisters, parents or grandparents.
- Safety glasses.
- Radial keratotomy
- Experimental or Investigational treatment or procedure
- Orthoptics, vision training, or medical or surgical treatment of the eye
- Artificial eyes

Where To Find The Answers To Your Questions

CLAIMS & LEGAL ACTION

■ **How Do I File a Claim?**

Medical, Dental and Vision Benefits 1

Preferred Pharmacy Program for Employees Who Elect the Great-West POS Medical Plan 2

What If I Don't Have My ID card with Me? 2

What If I Buy a Prescription Drug at a Non-Network Pharmacy? 3

Prescription Drugs for Employees Who Elect the Great-West PPO Medical Plan 3

Mail Order Drugs 4

■ **What If My Claim Is Denied?**

Notice of Denial Of Claim 5

Claim Review Procedures 6

Final Appeals Process 6

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How Do I File a Claim?

One of the most important aspects of your Plan is fast, accurate claims payment. As your Plan's claims processor, it's Great-West's job to see that your claims are resolved as efficiently as possible, but you play an important role too

Without complete information from you, your claims cannot be processed So for the fastest service, follow the steps outlined in this section when filing your claims

■ Medical, Dental and Vision Benefits

If You Use Network Providers

When you use Great-West PPO or POS Hospitals and Physicians, you don't have to file a claim Just present your identification card and pay any applicable co-pay at the time of service. Your card contains the information network providers need to bill Great-West for the balance directly

After a claim is processed, you'll receive an "Explanation of Benefits" (EOB) that details how your claim was paid. Your provider will bill you for deductible and co-payment amounts not paid by the Plan

If You Use Non-network Providers

If you use a non-network Hospital or Physician, you may have to file your own claims

For dental and vision benefits, you must file your own claims

- Obtain a claim form from your Employer.
- Complete all of the questions in "Part A - Employee Statement" of the claim form If you do not answer all the questions necessary, payment of your claim will be delayed
- Ask your provider to complete "Part B" of the claim form or simply attach an itemized bill to the form.
- Forward the completed form with itemized bills to the Benefit Payment Office listed on the claim form.
- If you use providers who don't require that you pay at the time of service, you may request that benefits be paid directly to them In this case, be sure to sign the line on your claim form that gives us authorization to send payment directly to the provider. If you do not sign this line, benefits will be paid directly to you.

  After your claim is processed, your provider will bill you for any charges not paid for by the "Plan."

- Submit claims promptly. The Plan will not pay claims that are submitted more than 15 months after they have been incurred.
- You only need to submit a fully completed claim form once each year for each family member.

After a claim is processed, you'll receive an "Explanation of Benefits" (EOB) that details how your claim was paid. A check for any amount payable to you will be attached to the EOB.

If You Incur Expenses Outside the United States

If you incur expenses outside the United States, you must pay the bill and file a claim to be reimbursed.

- The claim must be translated into English.
- The charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount of U.S. dollars.
- Along with the claim, you must send a receipt showing that you have paid the bill.

■ Preferred Pharmacy Program for Employees Who Elect the Great-West POS Medical Plan

Your ID card is the key to fast, convenient claims service and low out-of-pocket costs

- Present your ID card when purchasing drugs at any network pharmacy
- The pharmacy will ask you to sign a claim voucher, which lets them process your claim.
- Pay the pharmacist your co-pay, if any, for each prescription or prescription refill.

■ What If I Don't Have My ID card with Me?

If you don't have your ID card with you when you use a network pharmacy, you must pay the full price for the prescription and file a claim to be reimbursed

During the first 60 days you are covered for prescription drug benefits under this Plan, if you don't use your ID card your reimbursement will be the retail price of the drug less your co-pay. PCS will send this reimbursement directly to you.

However, after you have been covered for 60 days, if you don't bring your ID card with you, your reimbursement will be the PCS negotiated pharmacy discount price less your co-pay. PCS will send this reimbursement directly to you Your cost, which is retail price, is almost always greater than the PCS negotiated pharmacy discount price. You will not be reimbursed for the difference between retail price and PCS negotiated discount price That's why it's important to bring your ID card with you when you purchase drugs.

■ What If I Buy a Prescription Drug at a Non-Network Pharmacy?

If you purchase drugs at a non-network pharmacy, the Plan pays 50% of the covered charges for drugs after the co-pay

<u>If the Pharmacy Is a PCS Pharmacy</u>

If you present your ID card at a non-network PCS pharmacy, you must pay the pharmacist your co-pay for each prescription or prescription refill, plus an amount equal to 50% of the remainder of the covered charges for the drug.

<u>If the Pharmacy Is Not a PCS Pharmacy, or If You Don't Have Your ID card with You</u>

When you purchase drugs at a non-network pharmacy that is ***not*** a PCS pharmacy, or if the pharmacy ***is*** a PCS pharmacy but you do not bring your ID card, you must pay the full price of the prescription and file a claim to be reimbursed

- Ask your Employer for a Prescription Drug Claim form.
- Complete this claim form, attach your prescription drug receipt, and mail it to the address printed on the form.
- PCS will send the reimbursement directly to you.

After the co-pay, the amount of your reimbursement will be 50% of the remainder of the covered charges for the prescription drug had you used a network pharmacy. If your pharmacy charges more for a prescription drug than a network pharmacy would charge, you will have to pay the difference.

■ Prescription Drugs for Employees Who Elect the Great-West PPO Medical Plan

Your ID card is the key to fast, convenient claims service and lower out-of-pocket costs.

- Present your ID card when purchasing drugs at any PCS pharmacy. Participating PCS pharmacies have agreed to provide preferred pricing to cardholders.

- The pharmacy will ask you to sign a claim voucher, which lets them process your claim Your claim will be submitted electronically to the Benefit Payment Office, which means that you won't have to worry about filing a claim.
- Pay the pharmacist the preferred price for the drug.
- After a claim is processed by the Benefit Payment Office, you'll receive an "Explanation of Benefits" (EOB) that details how your claim was paid. A check for any amount payable to you will be attached to the EOB.

If you don't have your ID card with you when you use a PCS pharmacy, or if you use a non-PCS pharmacy, you must pay the full price for the prescription and file a claim with the Benefit Payment Office to be reimbursed.

- Ask your Employer for a claim form
- Complete this claim form, attach your prescription drug receipt, and mail it to the Benefit Payment Office listed on the claim form.

Please remember that, whether the PCS pharmacy submits your claim electronically or you file the claim yourself, benefits will be processed subject to the provisions of your Plan This includes any deductible, co-payment percentage, coverage limitations and benefit maximums.

■ Mail Order Drugs

- Ask your Doctor to prescribe needed medications for a 90-day supply, plus refills If you are presently taking medications, ask your Doctor for a new prescription
- Ask your Employer for a Mail Service Program brochure Complete the member profile form found in the brochure with your first order only. Be sure to answer all the questions for yourself and your Dependents. Make certain you include your ID card Number on the form
- Send the completed member profile form, your original prescription(s) and the co-pay for each prescription to the mail order service program. Your Employer can give you a pre-addressed order envelope to use.
- The mail order service program will process your order and return your medications to you by First Class Mail or UPS, along with re-order instructions for future prescriptions and/or refills. Allow 14 days for delivery.
- With your original prescription medication, you will receive a notice showing the number of times it may be refilled.
- When you need a refill, simply mail this notice, along with your co-pay, to the mail order service program in the pre-addressed order envelope.

- To avoid the risk of running out, order your refills at least two weeks before you need them.
- You may also request refills by calling the Customer Service Toll Free Number printed on the member profile form.

Obviously, there will be times when you need a prescription immediately On these occasions, you should have your prescription filled at a local PCS participating pharmacy. Be sure to use your ID card

If you need medication immediately, but will be taking it on an ongoing basis, ask your Doctor for two prescriptions.

- The first should be for a 14-day supply that you can have filled at a local PCS participating pharmacy.
- The second prescription should be for the balance, up to a 90-day supply Send it, with your co-pay, to the mail order service program immediately.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
Benefit Payments Office
P.O. Box 97313
Bellevue, WA 98009

(425) 827-9080 (Seattle Metro Area)
1-800-685-1010 (In/outside Washington)

What If My Claim Is Denied?

■ *Notice of Denial Of Claim*

If any benefits are denied, you will be sent a written notice of the denial This notice will include.

- Specific reason or reasons for the denial;
- Specific reference to the plan provisions on which the denial is based;
- An explanation of additional material or information needed to complete the claim.

You must be given notice of claim denial within 90 days after the claim is filed. If special circumstances require more than 90 days to act on the claim, another 90 days will be allowed. If such an extension is needed, you will be notified before the end of the initial 90-day period.

Claim Review Procedures

The process of reviewing your claim is addressed through various levels of the Benefit Payment Organization. You or your Doctor can direct your request for review to the Benefit Payment Office by letter or by calling the toll-free number on your ID card.

Member Services Representatives are trained to answer your questions. A Member Services Representative will respond to all inquiries within two working days. If the information does not satisfy you or your Doctor, a request for a claims review will be forwarded to the Member Services Supervisor in the local Benefit Payment Office.

Upon receiving your request for a claims review, Great-West will:

- Let you or your Doctor know who may be contacted in respect to the claims review within 20 days,
- Notify you or your Doctor of the final disposition of the claims review within 30 days.

If your claims review is not resolved within one week it will be forwarded to the Regional Benefit Payment Manager for review and resolution

If your claims review is not resolved by the Benefit Payment Manager, it will be forwarded to the Benefit Payment Review Department located at the Great-West's Executive Office in Englewood, Colorado.

The Benefit Payment Review staff may consult with Great-West's

- Medical Director (Dental Consultant if the claims review is of dental origin),
- Law Department,

to assist them in the claims review process.

You or your Doctor will be notified of the result of the claims review within 30 days of filing of the request for review.

Final Appeals Process

For self-funded benefits, your Plan Administrator makes the final decision on appealed claims.

If you or your Doctor is not satisfied with the final disposition of the claims review process, you can initiate an appeal by giving written notice to the Plan Administrator within 60 days after you receive the written claim denial This appeal must be filed before you may file any litigation

You or anyone authorized to act on your behalf may appeal the claim and ask to examine any pertinent documents. Submit in writing to the Plan Administrator the reasons why you believe that the claim should not have been denied, as well as any other information, questions or appropriate comments

■ Decision On Review

You will be notified of the final decision within 60 days after receipt of a request for review. If special circumstances require an extension of time for processing, a further 60 days will be allowed.

What If I Have Other Health Coverage?

You or your Dependents may be covered under more than one health plan. For example, you and your children may be covered under this Plan and under a group health plan sponsored by your spouse's employer If this type of duplicate coverage occurs, this Plan uses a method called "Coordination of Benefits" (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

The benefits provided by the plans listed below are considered in coordinating benefits

- This Plan;
- Any other group insurance or prepayment plan, including automobile "fault" or "no-fault" insurance, Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile "no-fault" insurance plan.

■ Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary This is done by using the first of the following rules that applies·

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.

- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the "birthday rule" will be used to determine the order of benefits. Under the birthday rule:
  - the plan of the parent whose birthday falls earlier in a year will be primary; but
  - if both parents have the same birthday, the plan that covered the parent longer will be primary.

  However:
  - If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
  - If the parents are legally separated or divorced, benefits for the child will be determined in this order:
    * first, the plan of the parent with custody of the child will pay its benefits;
    * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
    * finally, the plan of the parent not having custody of the child will pay its benefits.

    However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

    If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.
- A plan that covers a person as:
  - a laid-off employee; or
  - a retired employee; or
  - a Dependent of such an employee; or
  - a continuee under a state or Federal law;

  will determine its benefits after the benefits of any other plan covering that person as an employee.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:

- the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
- the plan covering the person as a retiree will determine its benefits *after* Medicare.

- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage Submit your claim first to the Benefit Payment Office listed on the claim form. When you receive the explanation of benefits from this Plan, send it, along with your claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit your claim first to the primary plan After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with your claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of·

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year

When the COB provision reduces the benefits payable under this Plan·

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A "credit savings" may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

"Allowable expenses" for a covered person are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

The following example illustrates how coordination of benefits works under this Plan

Coordination of Benefits	
Total allowable expenses	$2,000.00
Calendar year deductible under this Plan	$200.00
Percentage payable under this Plan after deductible	90%
Calendar year deductible under other Plan	$300.00
Percentage payable under other Plan after deductible	80%
If This Plan is Primary	
Total allowable expenses	$2,000.00
Calendar year deductible under this Plan	$200.00
Balance after deductible	$1,800.00
This Plan pays	$1,620.00 (90%)
If This Plan is Secondary	
Total allowable expenses	$2,000.00
Calendar year deductible under other plan	$300.00
Balance after deductible	$1,700.00
Other plan pays	$1,360.00 (80%)
Balance of allowable expenses after other plan paid	$640.00
Amount this Plan would pay if there were no COB	$1,620.00 (90%)
Amount this Plan pays after COB	$640.00
Credit savings	$980.00

Provision for Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness, a sickness, or a bodily injury incurred by you or one of your covered Dependents (a "covered person").

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness, sickness or bodily injury;
- the insurer or other indemnifier of the party or parties who caused the Illness, sickness or bodily injury;
- a guarantor of the party or parties who caused the Illness, sickness or bodily injury;

- the covered person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a worker's compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness, sickness or bodily injury.

Benefits may also be payable under this Plan in relation to the Illness, sickness or bodily injury. When this happens, Great-West may, at its option:

- subrogate, that is, take over the covered person's right to receive payments from the Other Party. The covered person or his or her legal representative will transfer to Great-West any rights he or she may have to take legal action arising from the Illness, sickness or bodily injury to recover any sums paid under the Plan on behalf of the covered person;
- recover from the covered person or his or her legal representative any benefits paid under the Plan from any payment the covered person is entitled to receive from the Other Party.

The covered person or his or her legal representative must cooperate fully with Great-West in asserting its subrogation and recovery rights. The covered person or his or her legal representative will, upon request from Great-West, provide all information and sign and return all documents necessary to exercise Great-West's rights under this provision

Great-West will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the covered person receives or is entitled to receive from any of the sources listed above. This lien will not exceed.

- the amount of benefits paid by Great-West for the Illness, sickness or bodily injury plus the amount of all future benefits which may become payable under the Plan which result from the Illness, sickness or bodily injury. Great-West will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

If the covered person or his or her legal representative:

- makes any recovery from any of the sources described above; and
- fails to reimburse Great-West for any benefits which arise from the Illness, sickness or bodily injury;

then:

- the covered person or his or her legal representative will be personally liable to Great-West for the amount of the benefits paid under this Plan; and

- Great-West may reduce future benefits payable under this Plan for any Illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

Great-West's first lien rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- your minor covered Dependent;
- the estate of any covered person; or
- on behalf of any incapacitated person.

Other Information You Need to Know

Incontestability

After this Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums.

During the first 2 years you are covered under this Plan, only a written statement signed by you can be used to contest the validity of your coverage. After your coverage has been in force for 2 years during your lifetime, no statement by you can be used to contest the validity of your coverage.

Notice of Claim

Great-West must receive written notice of claim within 20 days after the date of the loss or as soon as is reasonably possible. Notice can be given at Great-West's Executive Offices or to one of its authorized agents. Notice should include your name and the group policy or plan number.

Proofs of Claim

Written proof of claim must be given to Great-West as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of claim, unless the claimant was legally incapable of doing so.

Time of Payment of Claims

Benefits payable under this Plan will be paid as soon as written proof of loss is received.

Payment of Claims

Benefits will be paid to you, if living. If not, benefits will be paid to your estate. If any benefit is payable to:

- your estate; or
- a person who cannot give a valid release;

then Great-West can pay up to $1,000.00 to any relative it considers to be entitled to such payment. The Plan will be discharged to the extent of such payment made in good faith

You may request in writing that payments under this Plan be made directly to the person providing the services.

Legal Actions

You may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations and Autopsy

Great-West at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary. Great-West may also have an autopsy performed unless prohibited by law

Benefit Payments to a Representative of a Minor

In the case of a minor child who otherwise qualifies as a Dependent under this Plan, if the child designates a representative, then the Plan must pay benefits on behalf of that child to his or her representative, even if that person is not covered under this Plan. The person must:

- Submit written notice that he or she is the representative of the child on whose behalf the claim is made; and
- Provide evidence that the person qualifies to be paid the benefits.

ERISA General Information

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan

Health and Welfare Plan for Employees of PUGET SOUND FREIGHT LINES, INC. .

Employer

PUGET SOUND FREIGHT LINES, INC

3720 AIRPORT WAY SOUTH

SEATTLE, WASHINGTON 98134

PUGET SOUND FREIGHT LINES, INC
P O BOX 24526
SEATTLE, WASHINGTON 98124-0526

■ **Employer Identification Number (EIN) Assigned to the Plan Sponsor by IRS**

91-6032643

■ **Plan Number Assigned by the Plan Sponsor/Employer**

501

■ **Type of Plan**

Medical, Dental, Prescription Drug and Vision Benefits

■ **Funding**

See the section, "About This Plan"

■ **Type of Administration**

Contract Administration

■ **Plan Administrator**

DIRECTOR OF HUMAN RESOURCES
PUGET SOUND FREIGHT LINES, INC.
3720 AIRPORT WAY SOUTH
SEATTLE, WASHINGTON 98134
206-623-1600

PUGET SOUND FREIGHT LINES, INC.
P O. BOX 24526
SEATTLE, WASHINGTON 98124-0526

■ **Agent for service of legal process**

PLAN ADMINISTRATOR
3720 AIRPORT WAY SOUTH

SEATTLE, WASHINGTON 98134

PUGET SOUND FREIGHT LINES, INC

P.O BOX 24526

SEATTLE, WASHINGTON 98124-0526

Service of legal process may also be made upon the Plan Administrator

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

The Sources of Contributions to the Plan

The Sources of Contributions	
• Employee Coverages	
- Medical, Dental, Prescription Drug and Vision Benefits	Employer
• Dependent Coverages	
- Medical, Prescription Drug, Dental and Vision	Employer/Employee

Employee contributions, if any attributable to time periods for which the Employee is not covered under the Plan may be refunded by the Employer. Please contact your Plan Administrator for details

The Date of the End of the Year for Purposes of Maintaining the Plan's Fiscal Records

OCTOBER 31

Claims

Procedures to be followed in presenting claims for benefits and remedies for the redress of claims which are denied in whole or in part are described in this booklet.

Statement of ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

  However, Employers with fewer than 100 Employees at the beginning of the Plan Year are not required to:

  - allow examination of the Annual Report or Plan Description; or
  - furnish copies of the Plan Description, Annual Report, or any Terminal Report.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report except as described below. The Plan Administrator is required by law to furnish each participant with a copy of this Summary of the Annual Report. Employers with fewer than 100 Employees at the beginning of the Plan Year are not required to furnish a copy of the Summary of the Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g if it finds your claim is frivolous) If you have any questions about your Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U S Department of Labor, 200 Constitution Avenue, N W., Washington, D C 20210

GLOSSARY

■ Defined Terms

Accident 1
Actively at Work 1
Dentist 1
Dependent 1
Doctor 2
Employee 2
Employer 2
Experimental or Investigational 2
Hospital 3
Illness 4
Medically Necessary 5
Medicare 5
Medicare Benefits 5
Physician 5
Plan 6
Service 6
Totally Disabled and Total Disability 6

Defined Terms

The following defined terms have a special meaning with respect to the benefits outlined in this booklet. On each page where they appear throughout this booklet, they are capitalized.

■ Accident

A sudden and unforeseen event that:

- Causes injury to the physical structure of the body; and
- Results from an external agent or trauma; and
- Is definite as to time and place; and
- Happens involuntarily or, if it is the result of a voluntary act, entails unforeseen consequences

It does not include harm resulting from disease

■ Actively at Work

Employment on an active and full-time basis at the Employer's usual and customary place of business It does not include work performed away from the Employer's usual and customary place of business unless it is a location to which the Employer's business requires you to travel.

■ Dentist

A person licensed to practice dentistry

■ Dependent

- Your legal spouse,
- Any unmarried child under the age of 19, or
- An unmarried child under the age of 23 if he or she is a full-time student Before paying a claim, the Plan may require proof that this child is a full-time student.

For medical, dental and vision benefits, these age limits do not apply to a child who cannot support himself or herself due to a physical handicap or mental retardation. At reasonable intervals, but not more often than annually, the Plan may require a Doctor's certificate as proof of the child's handicap.

The term "child" means:

- Your children. This includes any legal step-child, adopted child or foster child.
- Any natural child of your minor Dependent.

For a child to be considered a Dependent, he or she must be chiefly dependent upon you for financial support.

The requirement that the child be chiefly dependent upon you for financial support will not apply if the child is eligible for coverage because of a Qualified Medical Child Support Order, or, if state law so requires, a court order or an administrative order of any state agency.

A legal guardian must provide guardianship papers.

Your Dependents must live in the United States or Puerto Rico to be eligible for coverage.

A person who is covered under this Plan as an Employee may not be covered as a "Dependent".

■ Doctor

A person licensed to practice medicine or osteopathy. Doctor also includes any other practitioner of the healing arts if:

- He or she performs a service:
  - Within the scope of his or her license; and
  - For which this Plan provides coverage; and
- State law requires such practitioner to be covered.

■ Employee

A person in the Service of the Employer.

"Employee" only includes a person who is a resident of the United States or Puerto Rico.

■ Employer

- PUGET SOUND FREIGHT LINES, INC. ; and
- Any Affiliated Companies listed in the application of the Employer. The Employer may add an Affiliated Company after the effective date of this Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

■ Experimental or Investigational

A drug, device, medical treatment or procedure which·

- Cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
- Is the subject of a current investigational new drug or new device application on file with the FDA; or

- Is being provided pursuant to.
  - A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
  - A written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives;
- Is being delivered, or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS);
- In the predominant opinion among experts:
  - As expressed in the published, authoritative literature, is substantially confined to use in research settings,
  - Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives, or
  - Is experimental, investigational, unproven or is not a generally acceptable medical practice; or
- Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Health Care Financing Administration (HCFA) of HHS;
- Is provided concomitantly to a treatment, procedure, device or drug which is experimental, investigational, unproven treatment; or
- Has not been performed at least ten (10) times and reported on in United States peer review medical literature.

Great-West's Medical Director may, in his/her sole discretion, determine that a drug, device, medical treatment or procedure which is deemed experimental or investigational under the above criteria, should nonetheless not be deemed experimental or investigational.

■ Hospital

Any of the following.

- An institution that meets all of the requirements shown below. It must:
  - Be legally established as a hospital.
  - Be open at all times.
  - Be operated chiefly for the care of sick and injured persons as in-patients.
  - Have a Doctor available at all times.
  - Have a registered nurse on duty at all times.

- Have organized facilities for diagnosis and major surgery. For treatment of mental illness an institution that does not have surgical facilities will still qualify as a hospital if it satisfies the definition of a "Hospital" in all other respects.
- Satisfy requirements, other than those above, specified by the law of the state where the covered person lives.
- Not be chiefly:
  * A nursing home.
  * A rest home.
  * A convalescent home or similar place
  * A place for treatment of alcoholism or substance abuse, unless required by state law.
  * A place for the kind of care that helps a person meet the activities of daily living.

• If state law so requires, an institution that meets all of the requirements shown below. It must:
  - Provide treatment for a specific condition.
  - Be licensed by the state licensing body or approved by the department responsible for such facilities in the geographical area in which it is located.
  - Provide recognized treatment for the condition for which it is licensed or approved to operate.

■ Illness

• An accidental bodily injury; or
• A bodily or mental disorder; or
• Pregnancy.

Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

What is considered an "Illness" will be determined by Great-West.

Illness will include any congenital defect of a newborn child.

Treatment of weight loss will not be considered treatment of an Illness unless the covered person is morbidly obese. Morbid obesity will be determined by Great-West.

Medically Necessary

Any services and supplies provided for the diagnosis and treatment of a specific illness, injury or condition must be.

- Ordered by a Doctor; and
- Required for the treatment or management of a medical symptom or condition, and
- The most efficient and economical service that can safely be provided to such person; and
- Provided in accordance with approved and generally accepted medical or surgical practice

Great-West may require proof in writing satisfactory to it that any type of treatment, service or supply received is Medically Necessary Medical necessity will be determined solely by Great-West.

The fact that a Doctor may prescribe, order, recommend or approve a service does not, in itself, make such service or supply Medically Necessary

Medical necessity does not include any:

- Experimental treatment, service or supply; or
- Service or supply that is for the psychological support, education or vocational training of the covered person; or
- Implant of any artificial organ for any reason whatsoever

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time.

Medicare Benefits

The coverage provided under Title 18.

Physician

A person licensed to practice medicine or osteopathy. Physician also includes any other practitioner of the healing arts if:

- He or she performs a service.
  - Within the scope of his or her license; and
  - For which this Plan provides coverage, and
- State law requires such practitioner to be covered.

Plan

PUGET SOUND FREIGHT LINES, INC. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The benefits described in this booklet constitute benefits available under the plan and are referred to collectively in this booklet as "the Plan."

Service

Work with the Employer:

- on an active, full-time and full pay basis; and
- for at least 30.00 hours per week for Office Employees;
- for at least 80 hours per month for all Hourly Employees.

Totally Disabled and Total Disability

Being under the care of a Doctor and prevented by Illness or injury:

- In your case, from performing your regular work; and
- In the case of your Dependent, from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

Arranged by:

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